Esther's Voice

A Story of a Health System
Failure and Hope for the Future

Who was Esther Winckler?

- A bright, articulate 77-year old woman with a good quality of life
  - *“Still in her garden, visiting neighbors, cooking meals, enjoying life and the possibility of travelling once again…once the severe pain in her hip and knee were minimized through elective hip replacement surgery”...*

Who was Esther Winckler?

An expert in her own life

- Esther informed her providers of her known (and documented) risk factors, such as
  - Tylenol 3 caused constipation
  - General anaesthetic was contraindicated
  - Allergy to morphine
  - *She received them all.*

What the Coroner Found

- Ischemia and infarction of the bowel and brain due to or as a consequence of:
  - prolonged postoperative oxygen de-saturation (critically low oxygen levels) and hypotension
  - complications experienced following surgery, including bowel obstruction, congestive heart failure, inadequate nutrition, and closed head injury due to a fall

What went wrong?
To make a long story short

- **Communication (TRANSITIONS)**
  - between care providers and patient and family
  - between care providers and disciplines
- **Assessment (Not knowing what did not know)**
  - Relationship between pre-op history and ongoing assessment findings - the impact of care on the patient
  - The basics: nutrition, bowel care, readiness for transfer, effect of sedation and analgesics
  - Unusual events: assessment head injury, root cause and effect of a fall

What went wrong?
To make a long story short

- **Accountability related to**
  - Overall clinical management of an elderly patient in acute care
  - Continuity of care between providers and between units
  - Someone to speak up and be ‘Esther’s voice’ in a poorly-designed system (the voice of the customer)
  - The ability to see many parts of the system working together or against each other (the voice of the process or system)

Esther's Story

- A volcanic eruption in a system which trembles every day
- A event of great magnitude and attention, representing the culmination of many small *system* failures and errors together
- A system in which the warning signs are available, but not on most peoples' radar screens
- The gap between scientific study and knowledge and what we actually do


USGS
USGS Photo by Austin Post,May 18, 1980

Esther's Story

- A story of *wrong care*, not bad people
- A story of a system in failure - a broken promise of safe, effective health care - a breach of trust
  - *"...the system is perfectly designed to achieve the results it achieves...*
  - *...we can put competent providers into a lousy system, and the system will win every time…*
  - *...therefore, if we want different levels of performance, we need to design different systems". -*
    - *Dr. Don Berwick, President and CEO, Institute for Healthcare Improvement*

Esther's Story

- An opportunity to restore the confidence of those we serve
  - Esther's daughter *refused to accept* a reality which many health care consumers *and* health professionals are resigned to
    - *"The problems were so systemic, at so many levels…this was not about being punitive at all but about making change in the system"*
      - Catherine Winckler.

Issues

- Historical practice of reacting to the ‘erupting volcano’ -simply trying to survive the catastrophe and stay out of harm’s way
- Not much attention to the questions:
  - How often does this volcano erupt? Every 200 years? Or everyday? What is the magnitude of impact? How can we anticipate and mitigate the next one?
- Responding to special cause or random cause variation in a system - being able to tell the difference and act accordingly

USGS Photo by Austin Post, May 18, 1980

Lessons Learned

- Build memory of our patients' stories into our work
  - to guide improvement and keep us in touch with our most compelling purpose…to care for people
- Build memory into our work processes
  - Move away from over-reliance on individuals' memory
  - Expecting care providers to remember too much leads to errors of omission and commission…
    - build systems and processes to create *memory in the system*

Lessons Learned

- **Need to establish systems for promoting and maintaining professional competency**
  - Optimize professional practice resources
    - ACGNN!!! GENI!
    - Professional associations, clinical nurse specialists, others who support integration of professional practice standards with everyday practice, people like YOU!

Lessons Learned

- **Need to establish systems for promoting and maintaining professional competency**
  - Ongoing education on high-volume, high-risk practice issues and Basic Care of Older Adults 101
    - Ongoing assessment of the Geriatric Giants - pain management, nutrition, bowel care, falls management, etc.
    - Asking ‘why?’ about unexpected findings
    - Ongoing communication between care providers and with patient and family *as full partners* in care
    - Comprehensive documentation that tells the patient’s story

Lessons Learned

- **Sustainability: Beating the 'Improvement Evaporation' Effect**
- Sustainability of *'right care'*
  - risk management and quality are not just the responsibility of the 'quality/risk management consultants in the organization - clarify roles and responsibilities of all the people in the process of care delivery and leadership within the organization

Lessons Learned

- **Sustainability: Make it easy to do the right thing, every time**
  - Reduce complexity, standardize major steps and build *extreme safety* into every process
  - Eliminate inappropriate variation
  - Translate evidence into practice through clinical pathways, comprehensive documentation systems, other care management tools
  - Build sustainability of right care into the design of improvements to make new ways of working the norm (cultural shift) and evaluate sustainability potential (ie NHS tools)

Lessons Learned

Spread - Moving Beyond 'Islands of Improvement'

- Establish communities of best practice
  - inter-disciplinary 'pods'
- Create leverage
  - to share the learning from one part of the organization across the organization
  - Develop structures to link improvement initiatives together and effectively communicate learning across programs, services, communities of practice within the organization

Lessons Learned

The Call for Courageous Leadership

- Move from traditional culture of blame to one of extreme safety and design processes that way
- Support courageous acts…encourage providers to trust their instincts about a bad situation and get it addressed
- Build the conscience for doing the right thing right everywhere in the organization
- Remember peoples' stories and keep them alive in our hearts and minds
- Remember patients (and their families) as experts in their own lives and include them as full partners. This is their journey.

Esther's Legacy

- "Many people - family, friends, strangers - have asked us why we're pursuing answers to our mother's death so vigorously. Why not just let it go, let time heal? Well, to answer this, you had to know our mother. She was a strongly principled individual who believed that if there was a wrong, it needed righting, and that we should never leave it to someone else to promote change if it was within our power to do so."
  - Esther's family

Esther Elsa Winckler

November 17, 1922 - March 5, 2000