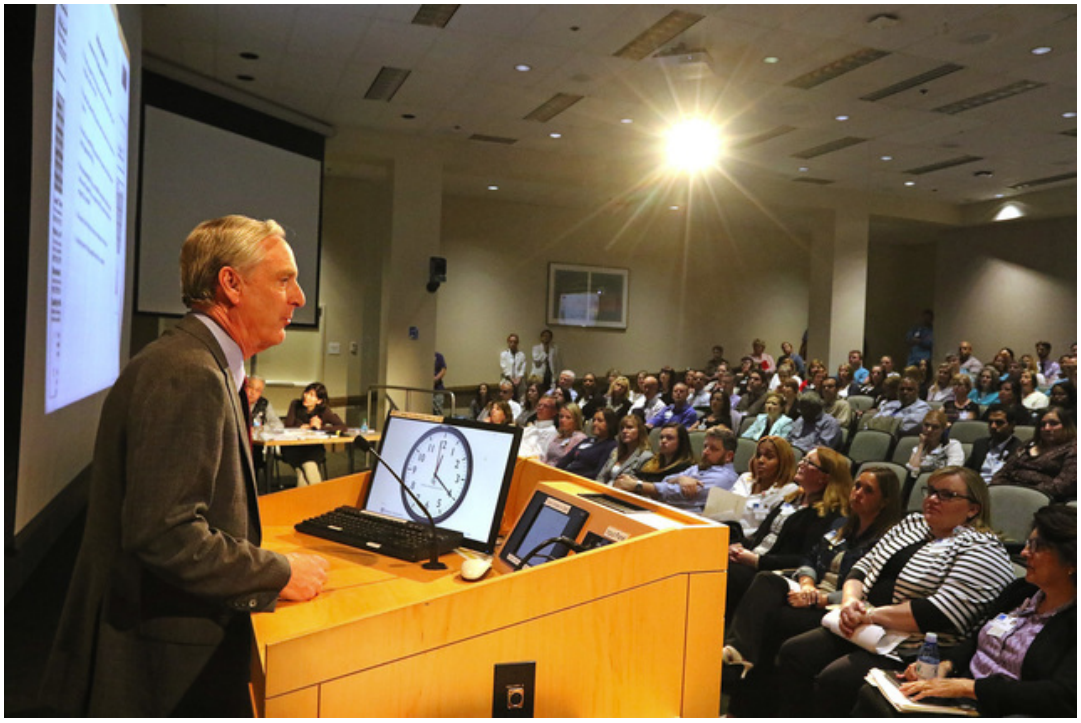
Jerry Large / Columnist

Tragic death drives quest for patient safety at Seattle hospital

Originally published June 12, 2016 at 12:00 pm *Updated June 12, 2016 at 7:01 pm*



Virginia Mason CEO Gary Kaplan, MD, addresses hospital staff members during a "report out" on hospital departments' efforts to achieve zero medical errors. (Greg Gilbert/The Seattle Times)

Virginia Mason continues its mission to fight medical errors.

Last month I wrote about medical errors and today I want to tell you about one health-care system's ongoing effort to prevent errors and improve its operation overall.

In 2002, Virginia Mason Medical Center (VMMC) adopted the Toyota Production System, which is known for dramatically reducing errors and improving efficiency in

manufacturing. Dr. Gary Kaplan, VMMC chairman and CEO, thought the system could be adapted for health care.

In November 2004, just two years into the change, Mary McClinton, 69, an active and beloved resident of Everett, was undergoing a procedure at Virginia Mason when she was injected with an antiseptic that killed her a few days later.

Her death was devastating to her family and community, and also to the hospital staff, Kaplan said.

The antiseptic had been on a cart in one of three unmarked bowls and looked identical to liquids in the other bowls, a dye and a saline solution. The arrangement was common, but it isn't anymore. Virginia Mason changed procedures, and so did other

hospitals, after the hospital announced the error and publicly apologized, and the story was widely carried in the media.

The hospital then doubled down on its culture change.

Kaplan set a goal of getting to zero errors in a field where the attitude had been that medicine is complicated and bad things are going to happen, and when they do you move on. The hospital has improved, but it's nowhere near zero defects, Kaplan said.

The system it set up lagged in informing the public about all of the 39 infections between 2012 and 2014 caused by duodenoscopes that retained bacteria. Eighteen of those patients died, though it wasn't clear that the infection caused their deaths. VMMC joined a family member's suit against the manufacturer.

There is power, though, in making that the goal, he said.

"If you believe we can get to zero," he said, "you act differently than if you say, 'Bad stuff happens.'" A lot of bad stuff can be prevented when prevention is central to the mission.

In the Toyota system, everyone is responsible for quality, and even the lowest level worker can shut down production to prevent a problem. Hospital staffers are expected to report errors and any problem that could cause harm to a patient, or negatively affect care. Early on, that required convincing workers that top executives had their backs when those workers reported errors.

The system also required standardizing procedures and putting the customer, in this case the patient, first. Some doctors worried about what putting patients first would mean for their status, Kaplan said. Others said that patients were already first, he said, but close examination showed that wasn't the case.

For instance, cancer patients often had to move from floor to floor for different procedures, and sometimes from building to building. Virginia Mason designed a treatment area that made life easier for patients.

Today anyone at any level in the organization can initiate a Patient Safety Alert, or PSA, whether for actual or potential problems, big or small. Teams come together to find solutions to problems they've identified. Every Tuesday morning, Kaplan convenes a quick hallway meeting to hear about progress on current projects. Each Friday at noon, Rapid Process Improvement Workshop teams report on their work.

I was invited to listen last Friday as four teams gave presentations on improving staffing efficiency, helping families deal with deaths, preparing spinal-surgery patients to leave the hospital and getting the operating room up and running more quickly.

Executives, doctors, nurses, housekeepers and social workers all participate in the process, working on teams depending on the project. Patients or families of patients serve on teams and bring their perspectives to the improvement process. Teams try out potential solutions, making videos that demonstrate problems and fixes. Everyone learns the process and the common language describing the steps and actions.

Openness and constant improvement are central to the culture, and each year a team is awarded a patient-safety award named for McClinton.

Kaplan and Virginia Mason have won awards for their work safeguarding patients and increasing efficiency, and so many other institutions were coming to learn from them that the hospital created a teaching program, Virginia Mason Institute, in 2008. Last year the National Patient Safety Foundation named Kaplan chairman of the Lucian Leape Institute, a patient-safety think tank.

The problem of medical errors is longstanding. A report called "To Err is Human" called attention to it in 1999, followed by "Crossing the Quality Chasm" in 2001.

What the hospital has found is that systems and procedures can either make human errors more likely or help prevent them. They've also learned that getting to zero defects is a continuous journey.

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