DUTCH
SAFETY BOARD

Summary
Vulnerable care: impasse in the Ruwaard van Putten Hospital

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Vulnerable care: impasse in the Ruwaard van Putten Hospital

Report issued by the Dutch Safety Board in December 2013

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Dutch Safety Board

The aim in the Netherlands is to limit the risk of accidents and incidents as much as possible. If accidents or near accidents nevertheless occur, a thorough investigation into the causes, irrespective of who are to blame, may help to prevent similar problems from occurring in the future. It is important to ensure that the investigation is carried out independently from the parties involved. This is why the Dutch Safety Board itself selects the issues it wishes to investigate, mindful of citizens' position of independence with respect to authorities and businesses. In some cases the Dutch Safety Board is required by law to conduct an investigation.

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NB: This report is published in the Dutch and English languages. If there is a difference in interpretation between the Dutch and English versions, the Dutch text will prevail.

SUMMARY

In November 2012 the Dutch Healthcare Inspectorate ordered the closure of the cardiology ward of the former Ruwaard van Putten Hospital. Leading up to this event, the hospital itself had already found increased and avoidable mortality occurring for certain cardiac diseases. This led to a debate on patient safety and, more specifically, on the use of morphine for terminally ill cardiac patients.

The aim of the investigations of the Dutch Safety Board is to enable stakeholders to learn from adverse events, with the aim of reducing the recurrence of incidents or limiting their consequences. An investigation by the Board may shed light on structural problems that are also relevant to parties outside the organisation that initially experienced the adverse event at the centre of the Board's investigation.

Focus and methods
This study answers the question of which safety issues were affecting the Ruwaard van Putten Hospital and which factors they were influenced by. The investigation takes the cardiac care at the hospital as a starting point and then widens its scope to include the organisation of care in the Ruwaard van Putten Hospital as a whole. Special attention is paid to the end-of-life care for patients with chronic heart failure.

The Dutch Safety Board has made use of various information sources in its investigation, including interviews with employees and physicians associated with the Ruwaard van Putten Hospital and an analysis of policy documents. To explore the extent to which the findings were unique to this hospital and whether they may apply elsewhere, the Dutch Safety Board also interviewed medical specialists, nurses and administrators at other hospitals.

Findings
Cardiac care in the Ruwaard van Putten Hospital in the period 2010 - 2012 was provided by experienced cardiologists, who often worked in an individualistic manner. Their main focus was the outpatient clinic, where they helped large numbers of patients under high time pressure. This resulted in their having relatively little time for patients submitted to the inpatient clinic.

The professional conduct of the cardiologists fell short in a number of areas. As a group, the cardiologists reflected little on their own actions. The quality of record-keeping was poor. They also sought little cooperation with other disciplines and for a long period there was uncertainty as to who was the chief cardiologist. In the hospital itself, criticism started being voiced about conduct of one of the cardiologists.

In certain areas of care, such as end-of-life care, procedures such as consulting colleagues, peer review and careful communication with the patient and the patient's relatives, as well as the documentation of this communication, are deemed especially important. Owing to the isolated nature of the cardiac care at the hospital, these procedures received insufficient attention.

End-of-life care is complex care, and its complexity is not so much medical as psychosocial. The cardiologists in the Ruwaard van Putten Hospital failed to appreciate this sufficiently, paying too little attention to communication with the terminally ill patients and their families. These heart patients and their families were sometimes kept uncertain about what awaited them: recovery, relief of the symptoms or death. Some relatives also had reservations about the advisability or necessity of the use of morphine. This led to feelings of insecurity and uncertainty, sometimes also among care providers.

Cardiac care at the Ruwaard van Putten Hospital did not comply with the latest insights into what constitutes good care. This concerned not only the communication with patients, as referred to above, but also the manner in which morphine was administered and the multidisciplinary organisation of care for terminal patients. A doctor who prescribes rapidly increasing doses of morphine to terminally ill patients and does little to explain and record his motives is bound to raise questions regarding his actions. Such conduct will after all blur the distinction between normal symptom management, palliative sedation and euthanasia, which can easily lead to misunderstandings among patients and relatives and doubts about the physician's conduct. This is what happened to the cardiologists in the Ruwaard van Putten Hospital.

New insights into palliative care have also not yet been generally introduced in other hospitals. For example, multidisciplinary palliative care consultation teams are not yet standard in all Dutch hospitals. However, there are noticeable differences between medical specialties. Oncology, for example, has been familiar with palliative care for a relatively long time, while other disciplines have only recently started considering what it has to offer.

The Dutch Safety Board has noted that, at the organisational level, the Ruwaard van Putten Hospital was affected by strained relationships between medical staff and management and that there was a strong focus on production. In part, this was the cause of the impasse that developed between the medical specialists and the Executive Board of the hospital. Their shared interest, particularly regarding their responsibility for good-quality and safe care, had been pushed to the background. Despite efforts by individuals and a number of successful changes, such as a file search of deceased patients, it was difficult to bring about lasting improvements to the quality of care on a number of wards, with initiatives aimed at implementing changes across the hospital foundering.

The relationship between care management and the teamwork of the hospital's care professionals, on the one hand, and the quality of the care actually delivered, on the other hand, is ambiguous. Good teamwork and management do not guarantee good quality of care, and poor teamwork and management do not necessarily result in poor quality of care. This is illustrated in the Danner Commission report which was commissioned by the Ruwaard van Putten Hospital. The report found that, while the

occurrence of preventable deaths at this hospital was comparable with that at several other hospitals, the Ruwaard van Putten Hospital suffered from considerable teamwork and management problems. Nevertheless, the Dutch Safety Board believes that good management and teamwork can only improve the quality of care provided, given that any mechanisms introduced to reduce the chance of error will function more effectively in such a climate.

Factors such as the complex interplay between medical specialists and hospital administrators and the hospital's funding system are not unique to the Ruwaard van Putten Hospital. They also have the potential to cause management and teamwork problems at other hospitals, resulting in possible adverse effects on the quality of care.

When stakeholders at a hospital fail to solve their problems, the involvement of external parties can sometimes help break the deadlock. Examples of such external involvement include the accreditation process by the auditing body NIAZ (the Dutch Accreditation Institute in Health Care), auditing by the Dutch Society of Cardiology and supervision by the Dutch Inspectorate of Healthcare. In the case of the Ruwaard van Putten Hospital, however, these interventions made no difference. Although the hospital had a long history of management problems, the hospital's performance based on 'hard' information such as indicators, accreditations and audits provided no reason to intervene for a long time, while 'soft' information on the problems involving cooperation at the hospital yielded an unclear picture. Specific problems in the provision of healthcare morphed and alternated over time and cropped up in various wards. In 2011, a new Executive Board seemed to be making headway in organising the hospital's affairs, but the underlying problems remained. Only when the Inspectorate received the very critical report from Medirede, after an accumulation of warnings from incident reports, did it feel there were sufficient grounds for intervening.

Based on the investigation, the Dutch Safety Board issued four recommendations to the KNMG, NVZ, NVVC and NIAZ.

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