Respectful Management of Serious Clinical Adverse Events

What’s Your Crisis Management Plan?
Outline

1. Goals of the White Paper
2. Response to Release and Content
3. The Content
   1. Realities of Practice
   2. Organizational Culture of Safety
   3. The Crisis Management Team and Plan
   4. The Prioritized Organizational Response
   5. Reimbursement and Compensation
   6. What to Do With a Crisis and No Plan
Goals of IHI White Paper

• Encourage and help organizations assemble clinical crisis management plans BEFORE they need to use them;
• Provide an approach to integrate these plans into organizations’ culture of quality and safety, with a particular focus on patient- and family-centered care and fair and just practice for staff; and
• Provide organizations with a concise, practical resource to inform their efforts in the absence of an organizational clinical crisis plan and/or culture of quality and safety.
Response to October 2010 Release

• Affirmed and interested:
  ─ 34,000 visits to content, 11,000 downloads
  ─ 6,000 web links to content
  ─ Presentations, endorsement, and use

• Recommendations to strengthen
  ─ Compassion, empathy
  ─ Reimbursement and compensation

• Challenges in implementation
  ─ Legal considerations, “trump card”
  ─ Dealing with “someone else's” error
  ─ Lack of organizational attention
“You just heard at this morning’s CEO leadership huddle that a 40-year-old father of five children died in the Surgical ICU last night, hours after receiving medication intended for another patient. Everyone is upset. Questions are flying around the hospital: What does the family know? Who did it? What happened? What can we say? Would the patient have died anyway (he was very sick)? Has anyone gone to the press?”

Talk to your neighbor for a few minutes. What would happen at your organization?
Realities of a Large Complex Imperfect Organization

- Preventable serious harm
- Fatal rare complication
- Violent crime
- Fire
- Drug diversion
- Identity theft
- Other breaches, etc.
Breaking A No-Win Cycle

- Serious clinical adverse event occurs.
- Organization is not transparent
- People close to the incident contact media.
- Media contacts the organization, gets “no comment,” or incorrect or superficial information.
- Media go looking everywhere for any information
- Information is supplied by people who really don’t know
- All parties are further traumatized by the strident, inaccurate media attention.
- The organization’s response becomes as big a story
Serious Clinical Event Defined

• Serious harm, potential serious harm, death, or a clear or present danger to one or more patients and/or to a community (psychological and physical)

• Possible definitions include but not limited to:
  — Harm categories G, H, and I, as measured by the NCC MERP harm index.
  — Sentinel events as defined by Joint Commission
  — The National Quality Forum Serious Reportable Events as a baseline list of serious clinical events.
  — HPI Safety Event Classification.

• Harm is usually, **but not exclusively**, preventable.
The call to IHI…and many others.

“We’ve just had a terrible error in the ICU. A patient died who shouldn’t have. What should we do?”
How To Respond?

• What should we do?
  — First hour, day, week, month
  — Moving forward

• Who should do it?

• What should we say, and to whom?

• Whose problem is this?
The Burden of the “Call”

• Devastation of the person calling
• Similarities of the stories
• Working with a blank sheet of paper
• Highly reactive, unbalanced response, and
• Underestimating the potential harm to all.
Every event is different, just as every care giver, every patient, every family member is different
In Summary, Crisis Management Steps

1. Avoid the crisis
2. Prepare to manage the crisis
3. Recognize the crisis
4. Contain the crisis
5. Resolve the crisis
6. Profit (by learning) from the crisis
Avoid the Crisis

Leadership and a Culture of Quality and Safety
A CULTURE OF SAFETY

“No one is ever hesitant to speak up regarding the well being of a patient (psychological safety), and everyone has a high degree of confidence that their concern will be heard respectfully and be acted upon.”

Michael Leonard
Assessing Your Policies, Procedures, Practices, Culture

1. Internal Culture of Safety
2. Malpractice Carrier
3. Policies, Guidelines, Procedures, Practices
4. Training
5. Disclosure Processes
6. The Disclosure
7. Ongoing Support
8. Resolution
9. Learning and Improvement
Manage the Crisis

The Team, The Plan, the Priorities
The Best Way To Manage a Crisis is to Have a Plan

- Create a team for planning
- Determine each potential problem’s likelihood
- Create a plan
- Simulate the plan
- Update the plan

Crisis Management: Master the Skills to Prevent Disasters by Harvard Business Essentials
Model Crisis Management Team

- CEO/COO
- CMO
- CNO
- Communications Officer
- General Counsel
- Patient Representative
- Representatives from: Risk Management / Quality Improvement / Patient Safety, Ethics, Pastoral Care
- Relevant service chief
- Others as appropriate for incident
  - Expert in Hospital Incident Command System
Crisis Management Team: Moving Forward

- Routine check-in daily to multiple times a day
- Maintain highly disciplined documentation and log
- Engage outside help through colleagues and consultants
- Listen and be prepared to hear things you don’t want to
- Embrace speed and flexibility
- Stay close to internal and external voices
- Consider implications for hospital/professional billing
- Imagine the worst; mitigate as possible
- Be prepared for inquiry from or the arrival of external accrediting and regulatory agencies
- Ensure knowledge management / improvement
Crisis Management Plan

- Internal notifications
- Crisis Management Team
- Priorities
  - Patient and family
  - Staff
  - Organization
    - External and Internal Communications
- External notifications and unannounced visits
Areas Requiring Focus
(In this order)

1. Patient and family
2. Staff, particularly those at the sharp end of the error
3. Organization
Seeking To Achieve for All Patient, Family, Staff, Organization

- Empathy
- Disclosure
- Support (including reimbursement)
- Assessment
- Apology
- Resolution (including compensation)
- Learning
- Improvement
Patient and Family

- Team disclosure
- Statement of empathy/sorrow
- Apology
- RCA participation
- Safety and support
- Reimbursement
- Compensation
- Resolution
- Learning

Never lose sight of the patient and family
Staff

- Coaching around disclosure
- Safety and support
- Engage in RCA
- Inclusion of all patient’s team
- Bring to resolution
- Assure learning

Never lose sight of the staff at the sharp end of the error
Organization

• Governance and executive team notifications
• Visible CEO & C-Suite
• Activated crisis team and leader
• Engaged Board of Trustees
• RCA underway
• Internal and external communications
• External notifications and unannounced visits
• Ongoing RCA, learning and improvement
Whose Problem Is This?

1. Board of Trustees (Governing Body)
   - Ultimately responsible and accountable for quality and safety
   - Engaged immediately and ongoing in system learning and improvement
   - Must fulfill their responsibility to the patient, family, and community

2. CEO
“I am accountable for those unnecessary deaths in our NICU”

Paul Wiles
CEO, Novant Health
Risk Assessment and Root Causes Analysis

• Commence immediately
  — Nothing more important on the schedule
• Include executive leadership
  — Comprehensive, fair and balanced process
  — Remove barriers
  — Learning
• Include staff close to the sharp-end
• Include patient / family as possible
• Fully integrate into governance and executive processes
• Assure follow-through on plan of correction

Note: Study conducting effective RCAs now.
Internal and External Communications

• What can we say?
• How can we say it?
• Who are we communicating to?
  — External
  — Internal
What Can We Say
Essential Messages

- Hospital apology, outrage, anger, regret that incident happened
- Disclosed to the patient/family--- informing and supporting them is priority
- Involvement of Board and leadership
  — understanding why systems failed patient and family
  — steps to prevent a similar occurrence
- Working with appropriate authorities
  — NOT a time to fight with authorities or Accreditors
- Understand this as a breech of trust and a failure to our community
How Can We Say It?

• Define your essential messages as clearly and concisely as possible

• Centralize and narrow the flow of information
  – Determine who will speak for the institution
  – All spokespersons must be briefed and prepared
  – Remind all staff to direct outside inquiries to Comm.
  – Communications Dept. should review communications to all core audiences

• Mobilize your allies
Internal Communications Critical

- All staff devastated when these events happen
- Need to understand what’s going on as staff, consumers, and sources of information
- The “drop a dime” phenomenon
  - Action not visible around immediate incident
  - Frustration over historical issue resolution
  - Organization not “telling the truth”

Note: Routine communication of errors facilitates communication of serious incidents.
Dealing with the Media

• In advance:
  — Up-to-date, tested media plan / crisis plan
  — Informed internal PR/Communications staff
  — Cultivated media
  — Media training for organization leaders

• On the heels of an adverse event
  — Rapid response
  — Honest; don’t stonewall
  — What happened, why, what’s being done?
  — Empathetic
  — Provide updates
What to Do When a Crisis Occurs, Without a Plan
Clinical Crisis Plans in Healthcare

- Only about 33% of respondents said their organizations had an “independent” crisis communication plan separate from the organization’s disaster plan.
- Another 37% of respondents said the crisis communication plan was part of the disaster response plan.
- 10% of respondents had no crisis communication or disaster plan.

No Plan

- Notify executive leadership and the Board.
- Establish a sense of urgency.
- Assemble an ad-hoc Crisis Management Team led by the CEO or other C-suite.
- Utilize this White Paper (Appendix A&B).
- Review the White Paper.
- Consider outside crisis management help.
- Contact other executive leaders (Appendix D).
- Never lose sight of the patient and family, staff, and organization.
Checklist: Respectful Management of a Serious Clinical Event

PROBING ALL STEPS

COMPLETING ALL STEPS

• Prepared Plans & Systems
• Internal Notification
• Crisis Team Activation
• Priority 1: Patient / Family
• Priority 2: Staff
• Priority 3: Organization
  • AE Management
  • Communications
• External Notification / Visits
Appendix B: Respectful Management of Serious Clinical Events Work Plan: Elements, Dimensions, and Milestones

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For Illustration Only
“If you take my pen and say you are sorry, but don't give me the pen back, nothing has happened.”

*Bishop Desmond Tutu*
Reimbursement and Compensation

• Reimbursement
  — Service Recovery
  — Out of pocket expenses
  — Examples: COPIC & Coverys‘ (formerly ProMutual Group)

• Compensation
  — Financial remedy for avoidable loss
  — Healthcare organization actively involved
  — Examples:
    ➢ Early: VA Lexington and University of Michigan
    ➢ Innovators: Veterans Health System, Stanford, CRICO, KP, many more
Communicating Around Errors that Happened Somewhere Else

- Patients and families need for respectful treatment should be at the forefront.
- Patients and families should not bear the burden of being fact finders for information about potential problems.
- When providers have serious concerns, a responsibility exists to proactively and thoughtfully explore while avoiding a rush to judgment.
- Institutions should develop supports to assist in preparing for conversations and for unbiased investigations in collaboration with other institutions to investigate and resolve quality of care concerns.
- Organizations must promote learning for the future with a culture of collective accountability.

Thomas Gallagher MD, Talking with Patients about Other Healthcare Workers' Errors: Ethical, Legal, Practical Considerations. 2008 Grant Greenwall Foundation
Supporting Organizations Dealing with Serious Clinical Events

Offer support, a helping hand, counsel to others dealing with tragic events and crises.
Learning From Events In Other Organizations: Could It Happen Here?
An IHI Resource Center

Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management

“In the aftermath of a serious adverse event, the patient/family, staff, and community would all say, ‘We were treated with respect.’”

http://tinyurl.com/IHIEffectiveCrisisMgmt
“When something goes wrong it is how the organization acts that redefines and reshapes the culture.”

J. Clough, Mt. Auburn Hospital
Comments, Questions, Answers

"Do not go where the path may lead; go instead where there is no path and leave a trail”

Ralph Waldo Emerson