



# *The Demands of Leadership During a Safety Crisis*

*6th Annual NPSF  
Patient Safety  
Congress*

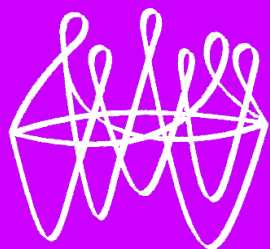
*Let's Get On With It*

*May 3-7, 2004  
Hynes Convention  
Center  
Boston, MA*

*James Mandell, M.D.  
President and Chief Executive Officer*

*Sandra L. Fenwick, M.P.H.  
Chief Operating Officer*

*Children's Hospital Boston*



# Crisis Management

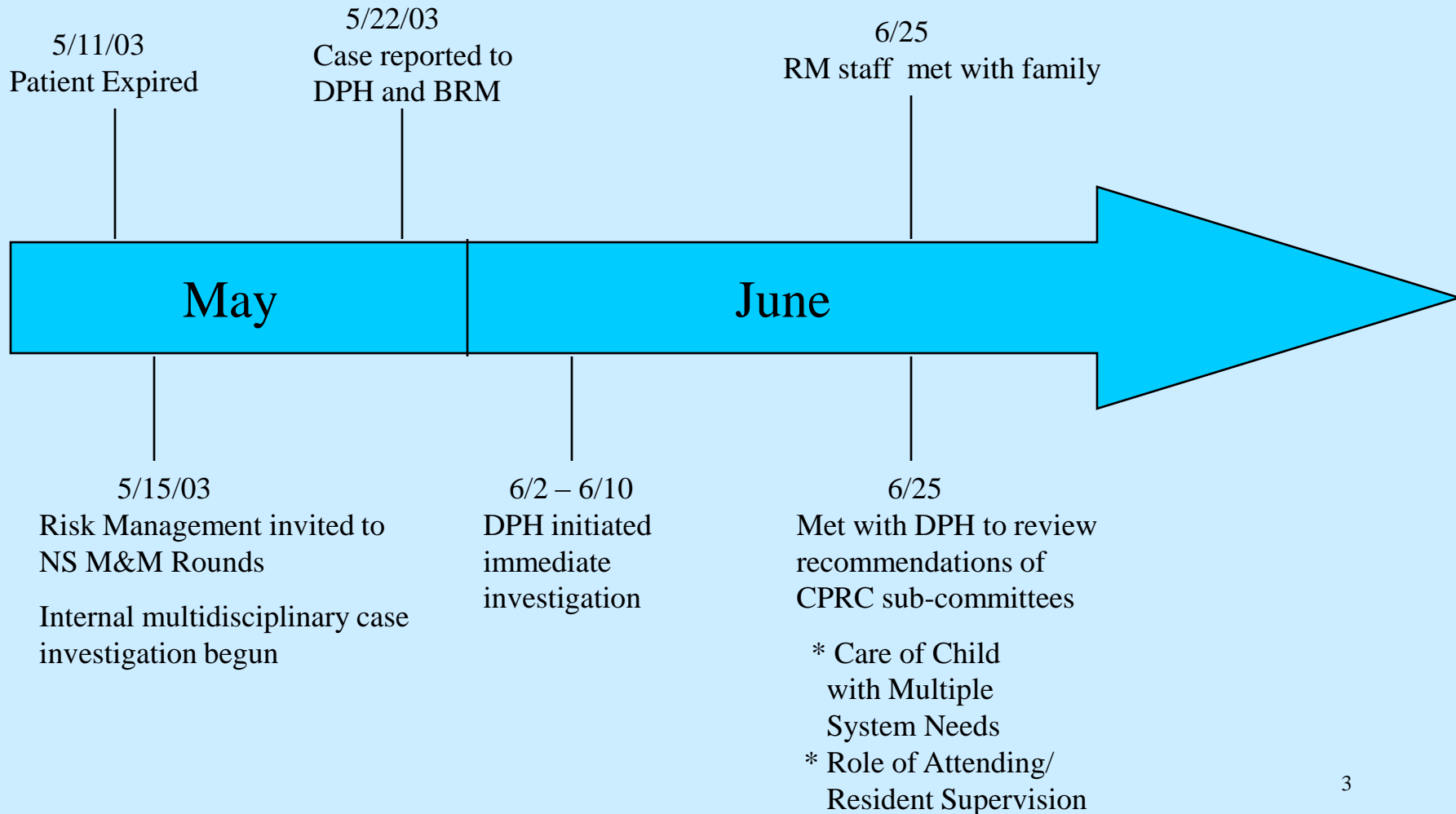
“Almost every crisis contains within itself the seeds of success as well as the roots of failure. Finding, cultivating, and harvesting that potential success is the essence of crisis management.”

Augustine, N.R. 2000: Managing the Crisis You Tried to Prevent in *Harvard Business Review on Crisis Management*. Chapter 1, pp 1-31.

# ADVERSE EVENT

- 5 year old male with severe seizure disorder admitted for placement of subdural electrodes on 5/9/03.
- Unexpected postoperative seizure, fever and cerebral edema.
- 5/11/03 patient expired.

# Sequence of Event Management May-June 2003



# **Key Internal Learnings and Immediate Actions**

**Initiated “Implementation Steering Committee”  
to make changes:**

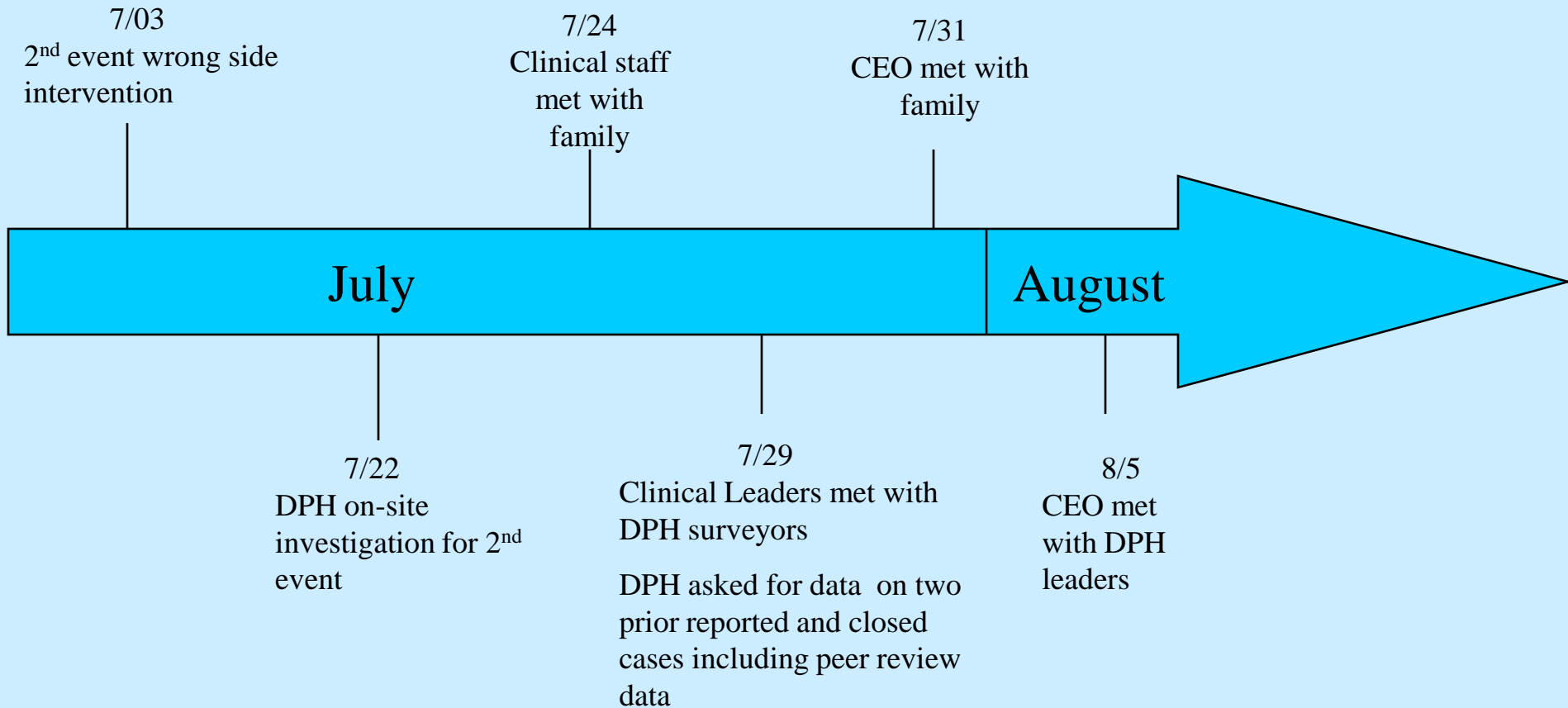
- Care planning and coordination
- Communication
- Lines of responsibility/accountability
- Challenging the clinical strategy
- Handoffs
- Attending Physician Oversight
- Team based practice with clear delineation of roles

# **In the Midst of Managing the First Event Another Event Occurred**

On July 3, 2003

A second sentinel event – child received radiologic intervention on wrong side (kidney)

# Sequence of Event Management July, 2003



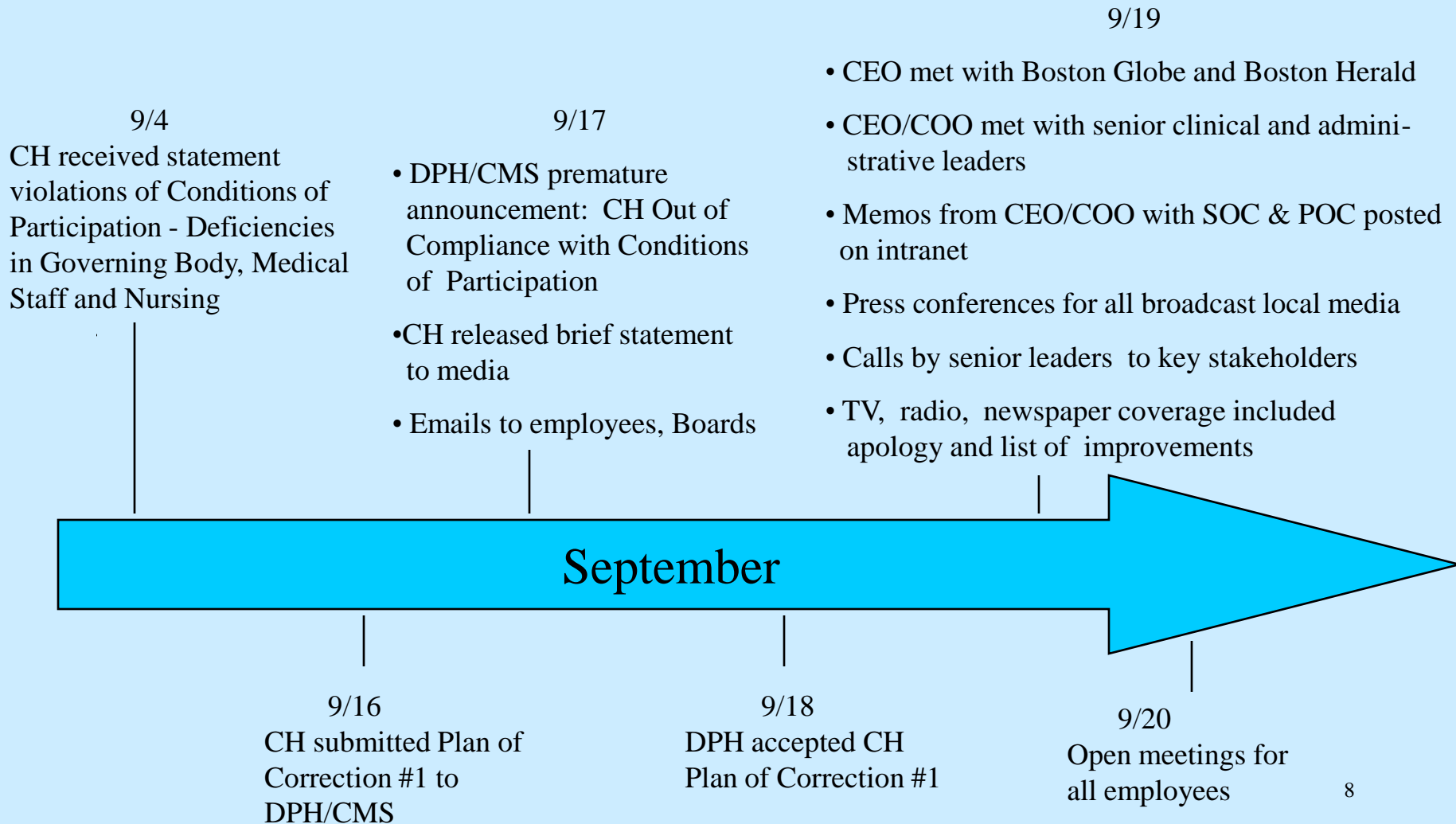
# Media and Stakeholder Communications Planning August, 2003

- CEO/COO met with all clinical staff involved in incidents
- Public Affairs coordinated plan for release of information to media with DPH, training videos
- Small press briefs in Boston Globe and Boston Herald
- Prepared written statements for employees, Board, Trust Board, parents
- Lists of internal and external stakeholders to communicate with one-on-one; email; fax; meetings



# Sequence of Event Management

## September, 2003



# Broadcast Coverage

## September 18-20, 2003

- WCVB-TV (ABC)
- WBZ-TV (CBS)
- WHDH-TV (NBC)
- NECN – cable
- UPN38
- WB56
- WJAR-TV (R.I.)
- NPR Radio
- WBZ Radio
- WBIX Radio

# Print Coverage

## Children's Hospital scrutinized

Patients' case spurs questions, leads to review by Mass. US

By Anne Burdick

**Boston**—The death of a young boy in a hospital ward last month has led to a comprehensive review of the Children's Hospital, Boston, by the state health department.

The review, which is the first of its kind in the state, was prompted by a letter from the parents of the boy, who died of a rare and fatal disease.

The review will look at the hospital's procedures for admitting patients, the care they receive, and the quality of the medical staff.

The review will also look at the hospital's financial operations, and whether the hospital is providing the best possible care for its patients.

The review is being conducted by the state health department, and will be completed in several months.

The review will be a thorough one, and will involve a number of different groups, including the hospital's board of directors, the medical staff, and the state health department.

The review is being conducted in a confidential manner, and the results will not be made public until the review is complete.

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## Doctors were unsure of roles as boy died at Children's

By Anne Burdick

The 6-year-old boy who died last month at Children's Hospital, Boston, was the first to be treated for a rare and fatal disease.

The boy's death has led to a comprehensive review of the hospital's procedures for admitting patients, the care they receive, and the quality of the medical staff.

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## DPH probes Children's Hospital

By MICHAEL LEBLANC

**Boston**—The Department of Public Health is probing the death of a young boy who died last month at Children's Hospital, Boston, after a long and complicated illness.

The review will look at the hospital's procedures for admitting patients, the care they receive, and the quality of the medical staff.

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Health, education & science

## A Better Life

### Leading hospitals drop the ball

Children's Hospital of Boston and Children's Hospital of Orange County, Calif., have been named in a report by the state health department as among the worst hospitals in the state for patient safety.

The report, which was released last month, was based on a survey of 100 hospitals in the state.

The survey found that the two hospitals had the highest number of patient safety incidents, and were among the worst in the state for patient safety.

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### New England in brief

#### BOSTON

### DPH investigates incident at Children's

The Department of Public Health is investigating an alleged case of a rare and fatal disease at Children's Hospital, Boston.

The investigation is being conducted in response to a letter from the parents of the boy, who died of a rare and fatal disease.

The investigation will look at the hospital's procedures for admitting patients, the care they receive, and the quality of the medical staff.

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Janet  
Blujes

Gilbert  
Blujes



# Boston Globe

## Many specialists, one patient, one death

State investigators have found that a 5-year-old epileptic boy died without receiving proper treatment at Children's Hospital despite the presence of two nurses, two doctors, and others who came later or were available by phone. The confusion at his bedside is emblematic of the sometimes tangled lines of communication at a sophisticated teaching hospital. Children's is taking measures to improve the supervision of future patients.

### WHAT HAPPENED TO THE PATIENT

Six hours after successful surgery to implant brain sensors into the boy, he patient began suffering a whole-body seizure. Despite the presence of neurosurgeons, epilepsy specialists, and medical intensive care unit (MICU) staff, the patient suffered a heart attack more than 90 minutes after the seizure started. Even with successful emergency surgery to remove the brain sensors, he died two days after being admitted to the hospital.

SOURCES: Investigation report by the federal Centers for Medicare & Medicaid Services; MedLine; National Heart, Lung, and Blood Institute

### POINTING THE FINGER

Both doctors at the scene and those in supervisory roles told federal investigators that other individuals or departments were responsible for managing the patient's treatment during the seizure. The patient did receive anti-seizure drugs, but not in high enough dosages.

#### Neurosurgeon

Said epilepsy staff or medical intensive care unit (MICU) staff are responsible for post-operative care.

#### Neurosurgery resident

Assumed the seizure was being managed by the MICU fellow and the epilepsy fellow on the phone.

#### MICU director

Said MICU staff don't assume responsibility for surgical patients; the responsibility belongs to the surgical staff.

#### MICU attending

Said neurological staff was responsible for managing care during the seizure.

#### MICU fellow

Thought the seizure was being managed by neurosurgical resident at bedside and epilepsy fellow on the telephone.

#### Epilepsy specialist #1

Said MICU staff or neurosurgical team were responsible for managing care during the seizure.

#### Epilepsy specialist #2

Said MICU staff was responsible for care.

*Patient's primary doctor, but not on call that night*

#### Epilepsy fellow

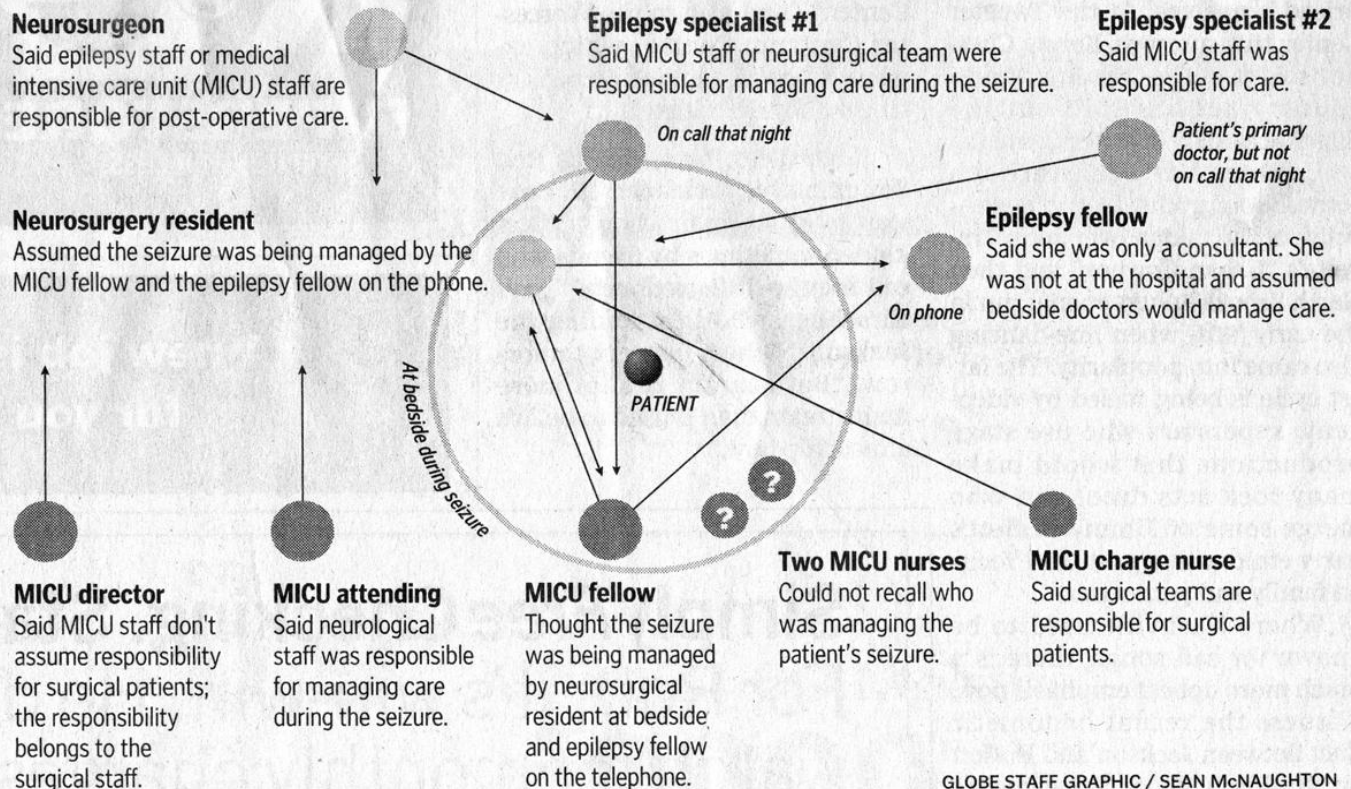
Said she was only a consultant. She was not at the hospital and assumed bedside doctors would manage care.

#### Two MICU nurses

Could not recall who was managing the patient's seizure.

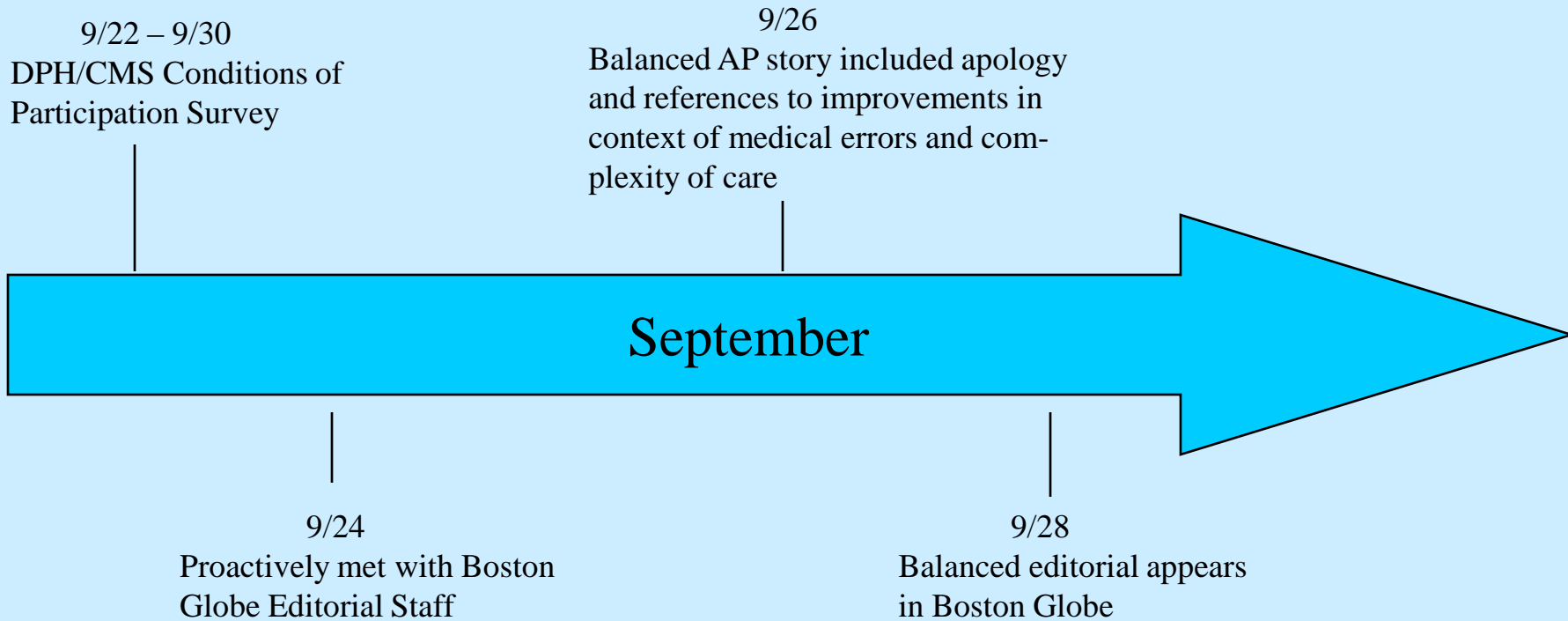
#### MICU charge nurse

Said surgical teams are responsible for surgical patients.



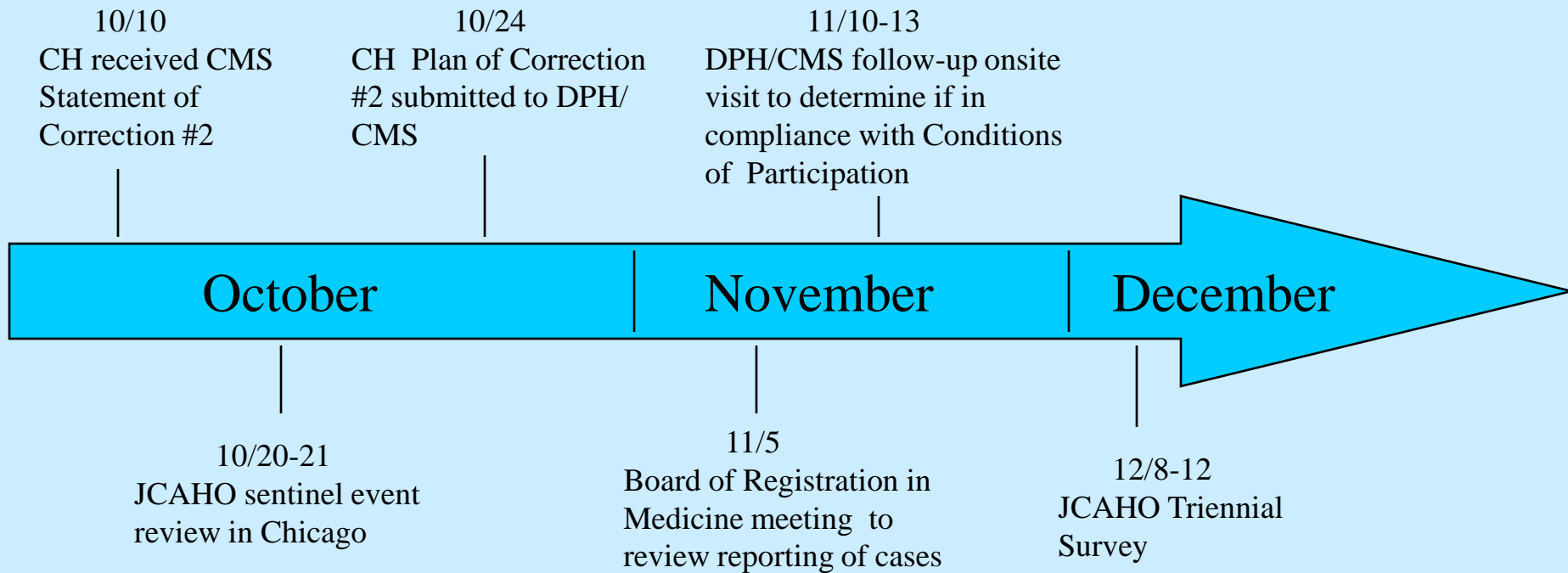
GLOBE STAFF GRAPHIC / SEAN McNAUGHTON

# Sequence of Event Management September 2003



# Sequence of Event Management

## October – December 2003

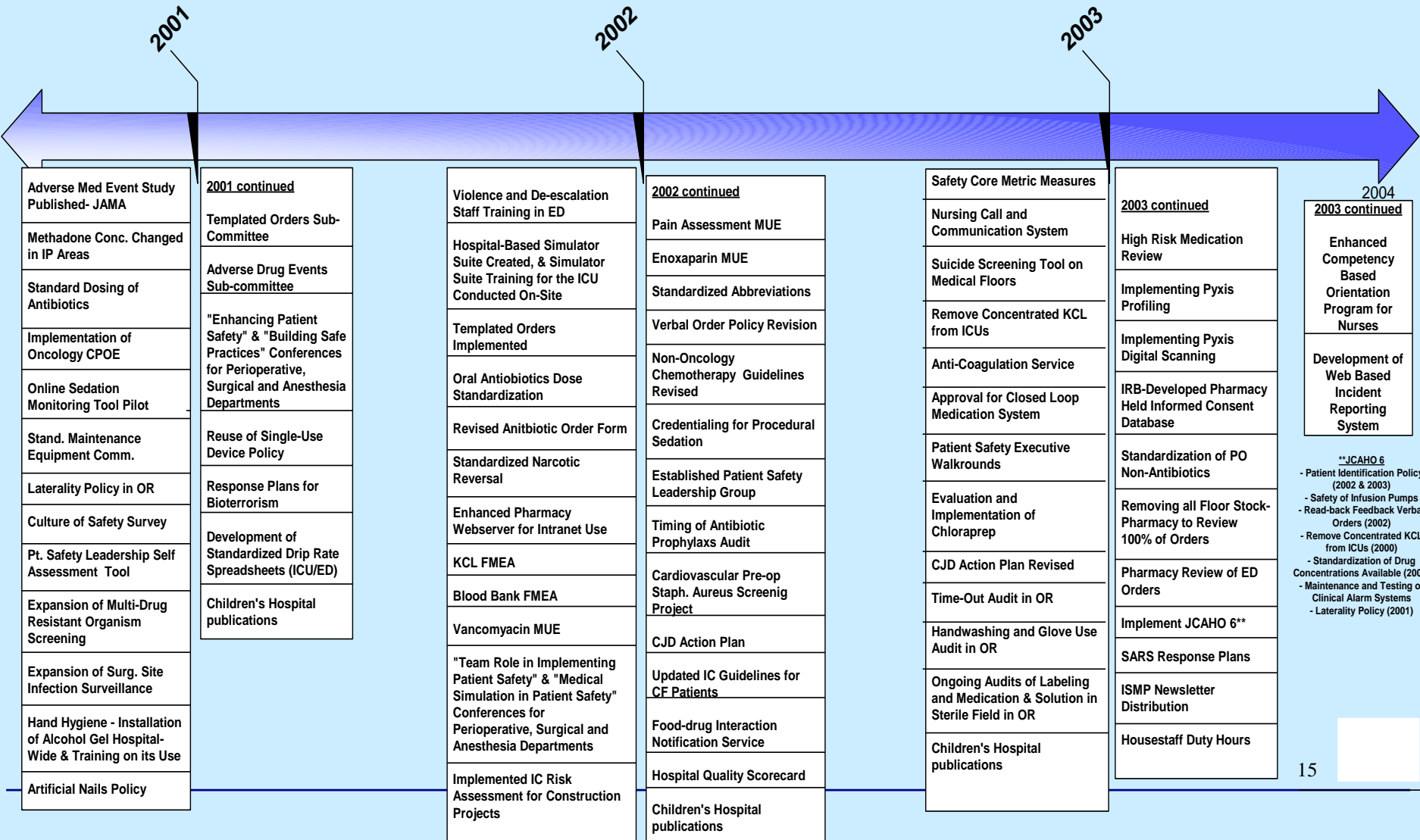


# What More Did We Learn?

- Culture -
  - Thought we were doing excellent quality care
  - Thought we had good Q & PS systems in place
  - Not consistent, relentless questions, measurement/data
  - Did not see this coming
  - Focus of Board, leadership – on finances, larger strategy
- Failure to Act - Committees established post-review of 2 adverse events in 2002 with recommendations. Diligent, focused implementation of recommendations not pursued fast enough
- Unclear leadership accountability for patient quality
- Systems to support caregivers inadequate to close gaps in care delivery

# These Events Occurred within System of 10+ Years of Focus on Patient Safety

## Patient Safety Initiatives 2001-Present



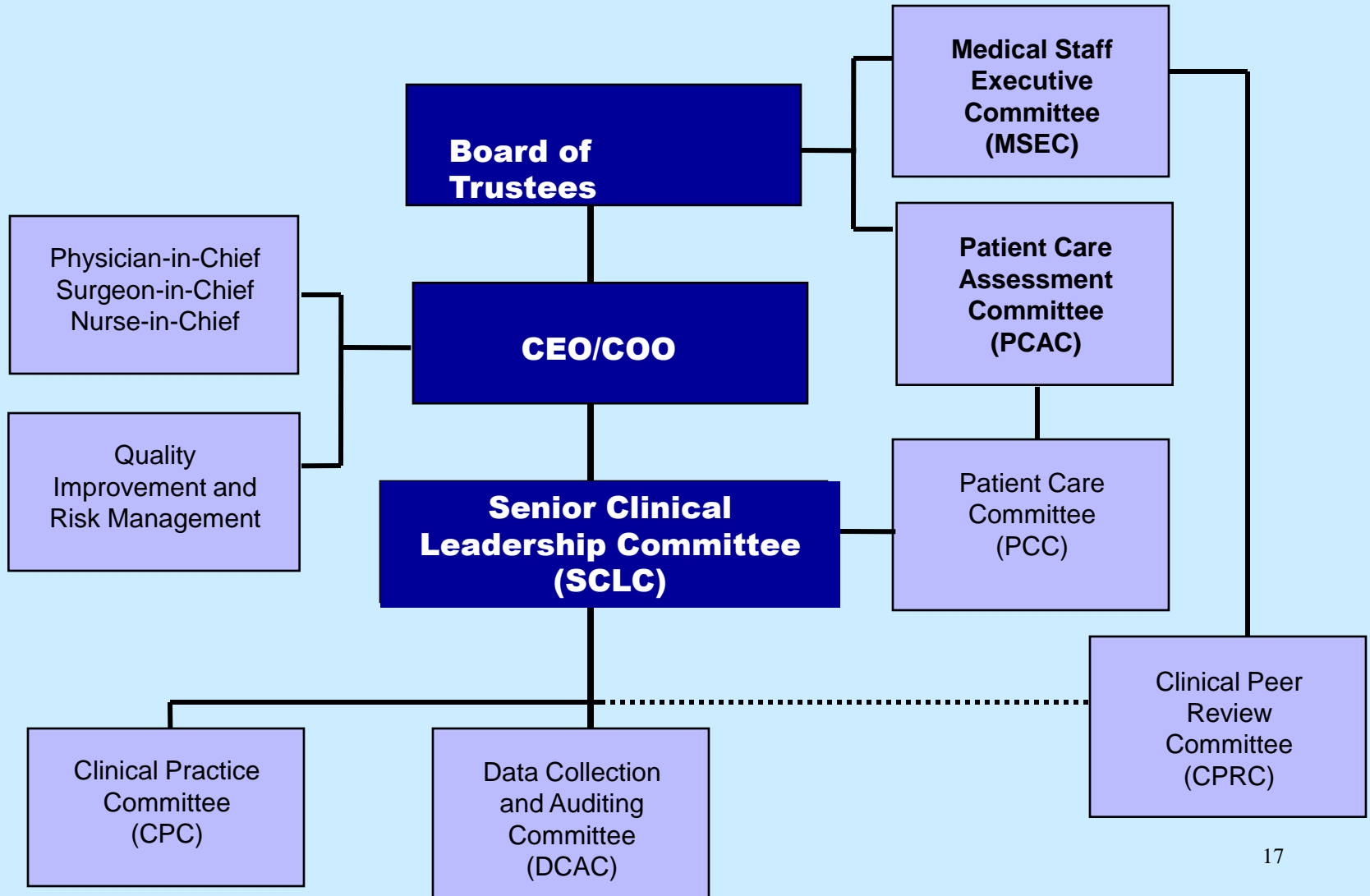


# What Did We Decide to Do With This Information?

- These events must be used as a “call to action”
- We must continue a non-punitive approach while holding leadership accountable
- There must be transparent learning for ALL

# How Did We Organize for Change?

## Quality Oversight Committees



# What Did the Senior Clinical Leadership Committee Do?

- Managed Immediate Crisis
  - Communications
  - Regulatory agencies
  - Plans of Correction
  - Measurement of achievement
- Developed Policies
  - Attending/resident supervision
  - Associate attending
  - Consultation
  - Single standard of care in MSICU
  - 24/7 attending coverage in MSICU
  - On call lists
  - Standard mandatory computer use for clinical notes
- Called for external review of NS and QI/RM
- Created ombudsman




# What Did the Senior Clinical Leadership Committee Do?




- Closed ICU annex, reorganized with different staffing/patient population
- Reviews all adverse events within 24 hours
- Reviews all data from the Data Auditing and Compliance Committee
- Mandated quarterly reporting of the Data Auditing and Compliance Committee to the Patient Care Assessment Committee of the Board
- Mandated monthly meetings of the Patient Care Assessment Committee

# **How Are We Tracking Progress?**

- **Plan of Correction Tracking Document**
- **Plan of Correction Critical Success Factors.**

# Plan of Correction Tracking Document

Source	Section	Plan of Correction	Status
POC 1. Governing Body (A 016, A 022)	1.B.	The Board has charged the Chief Executive Officer and will hold him accountable for putting in place the structures, policies, processes and tools necessary to implement this Plan of Correction. The specific action steps, timelines and remediation have been reviewed and approved by the Board and detailed progress reports will be monitored by the Board on a regular basis to make certain that these changes are embedded in the organization. More broadly, the Board charges the Chief Executive Officer with enhancing the culture of safety at Children's Hospital, and ensuring that patient safety remains a part of every staff and employee's responsibility.	
POC 1. Governing Body (A 016, A 022)	1.B.1.	The Patient Care Assessment Committee will increase the frequency of its meetings from quarterly to monthly; additional lay members of the Board of Trustees will be added to the membership of the Committee along with a member of the public; all members of the Board of Trustees will be invited to attend and participate in meetings of the Committee; and the Committee will report quarterly to the full Board of Trustees, and more often as needed. At each meeting, in addition to existing reports, the Committee will receive reports from the Senior Clinical Leadership Committee and the Implementation Committee.	
9-17 Response to DPH	Q1	1. Q: Who chairs the Patient Care Assessment Committee? A: The Vice Chair of the Board of Trustees Q: Who is a Risk Management/Quality Improvement person on the PCAC? A: The Corporate Director of Performance Improvement and Compliance and the two senior Risk Manager/Quality Specialists are present and staff the PCAC.	

 <i>Insufficient Progress</i>	 <i>In Process - substantial Movement to implement</i>	 <i>Completed / Established</i>
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# Plan of Correction Critical Success Factors

<b>1. Associate Attending Physician Policy</b>					
	<b>Current</b>	<b>Previous</b>	<b>Change</b>	<b>Data Frequency</b>	<b>Status</b>
<b>Number of patients with underlying medical problems identified</b>					
<b>Number of cases presenting with an associate attending</b>					
<b>Number of cases for which associate attending became involved as a result of this policy</b>					

<b>2. Clinical Consultations (actual metrics pending feedback from Data Auditing Compliance Committee)</b>
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	<b>Current</b>	<b>Previous</b>	<b>Change</b>	<b>Data Frequency</b>	<b>Status</b>
<b>Metric #1</b>					

<b>R</b>	<b>Y</b>	<b>G</b>
<i>Insufficient Progress</i>	<i>In Process - substantial Movement to implement</i>	<i>Completed / Established</i>

# What Worked: Communication Strategy

- Proactive strategy with strategic message points
- Balance of Apology/Accountability, Transparency and Confidence
- Accepted full responsibility
- Messaging varied by stakeholder
- Stakeholders: Board of Trustees, Medical Staff, employees, other patients and families, partners, donors, legislators, payers, community colleagues and leaders, media



# What Worked: Overall

- Mobilized leadership
- Visibility
- Assured day-to-day operations
- Capitalized on opportunity for transforming the organization
- Communicated strategically to all stakeholders
- Created new systems to sustain gains
- Communicated results

# What Are Ongoing Cultural Changes?

- Building a culture of safety
- Vigilance
- Accountability/Transparency
- Non punitive culture
- Continuous measurement and feedback
- Commitment to continuous improvement
- Openness to change, embrace a new way
- Never be satisfied

# Conclusions

- Crises are inevitable
- Do the right thing
- Stay focused
- Convey humility, confidence, accountability and willingness to learn and improve.
- MEAN IT!