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

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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.

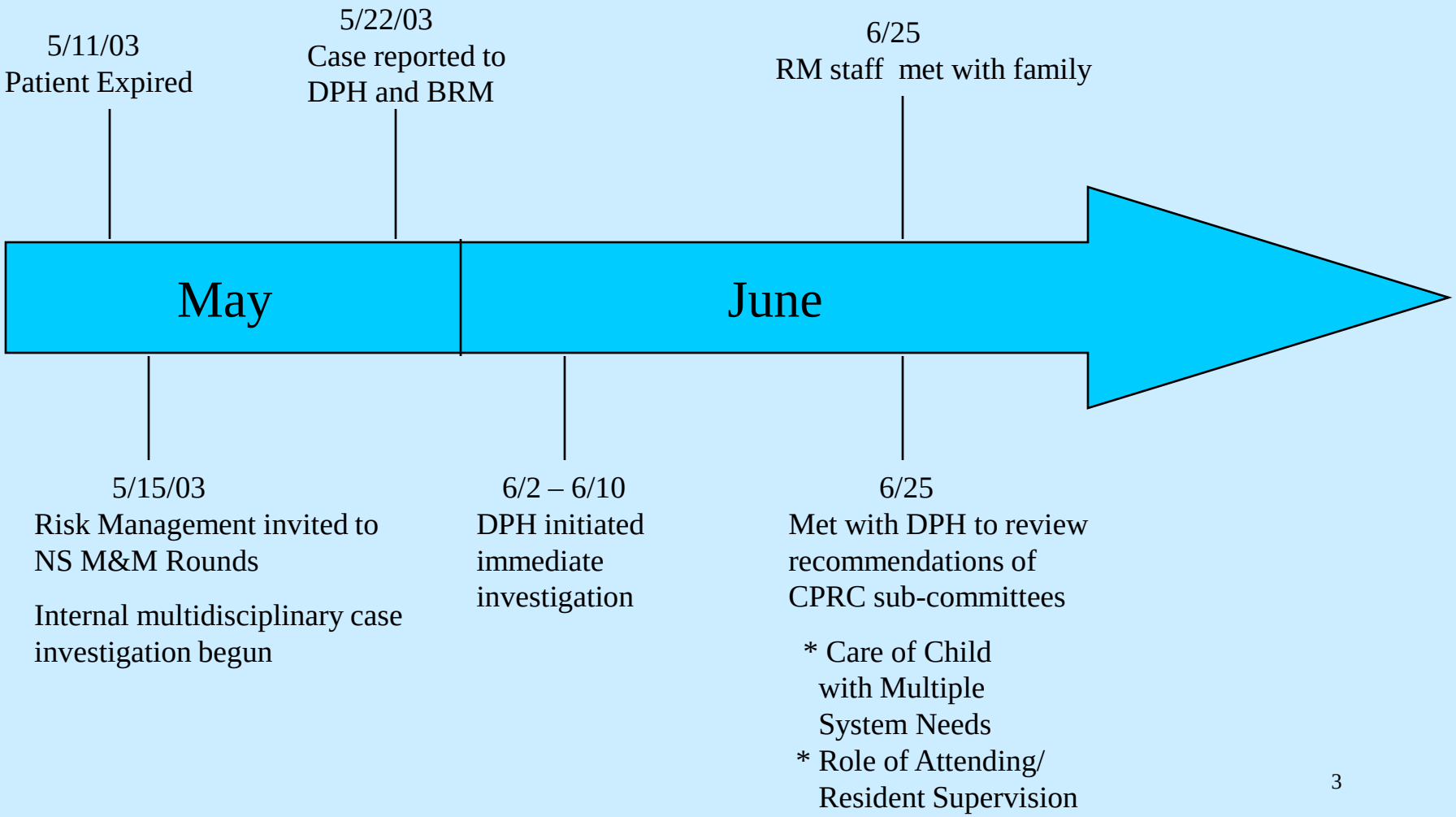
ADVERSE EVENT

- 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:

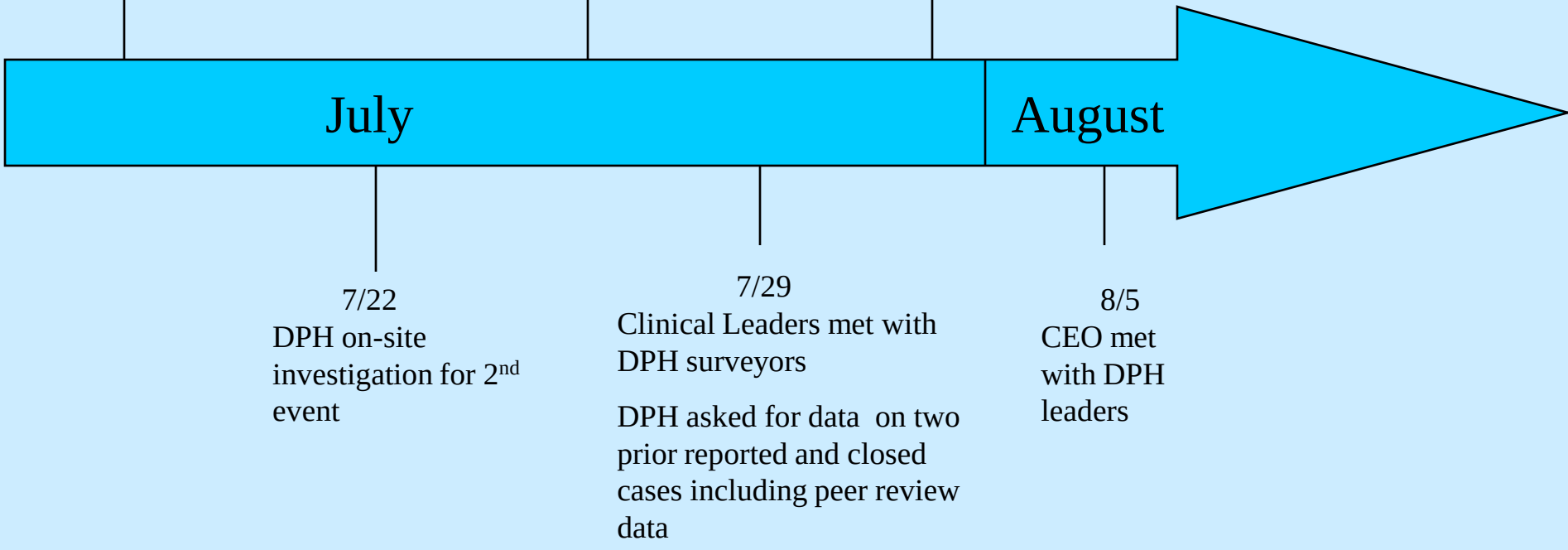
- Care planning and coordination
- Communication
- Lines of responsibility/accountability
- Challenging the clinical strategy
- Handoffs
- Attending Physician Oversight
- Team based practice with clear delineation of roles

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)

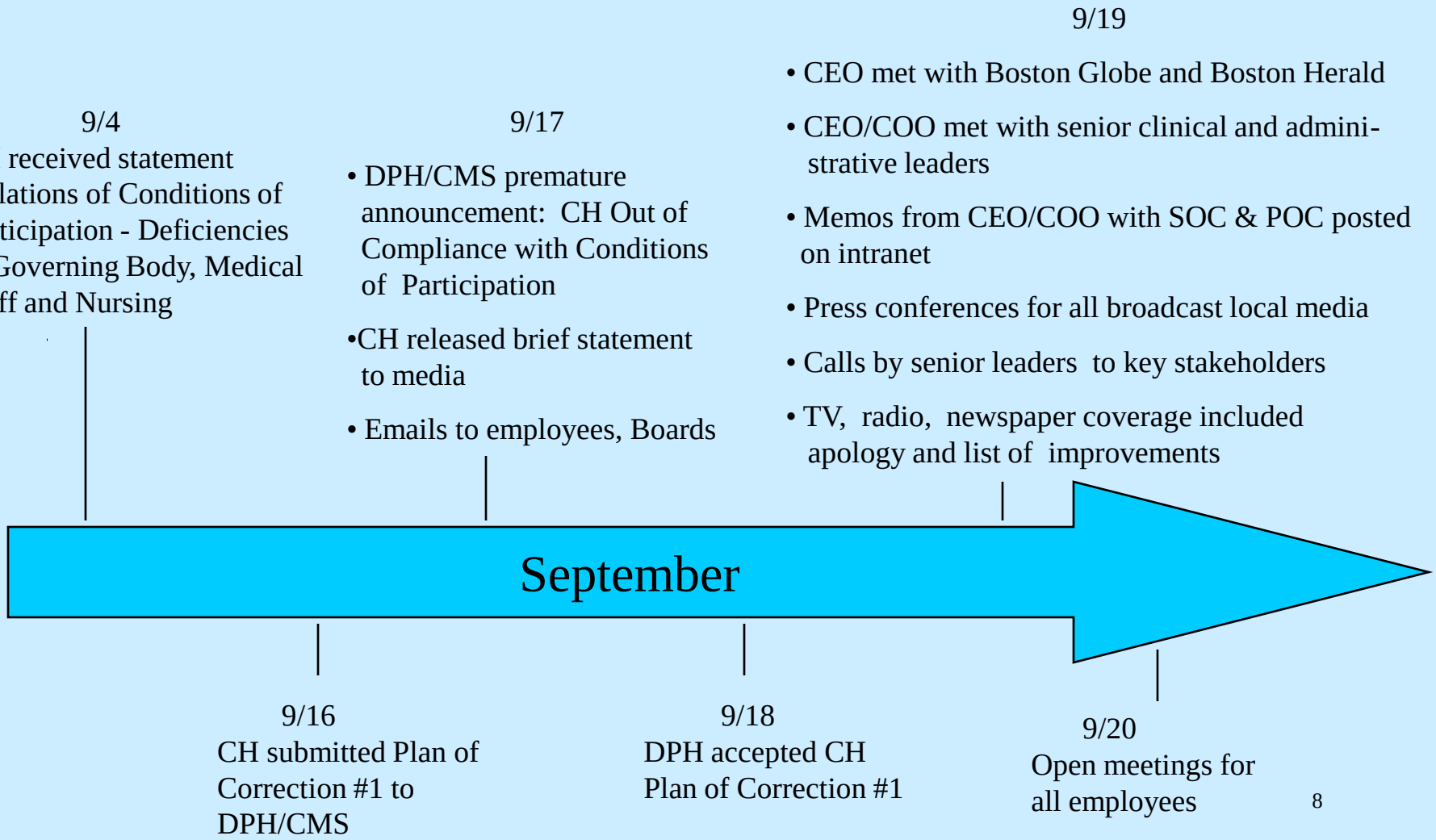
Sequence of Event Management
July, 2003



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

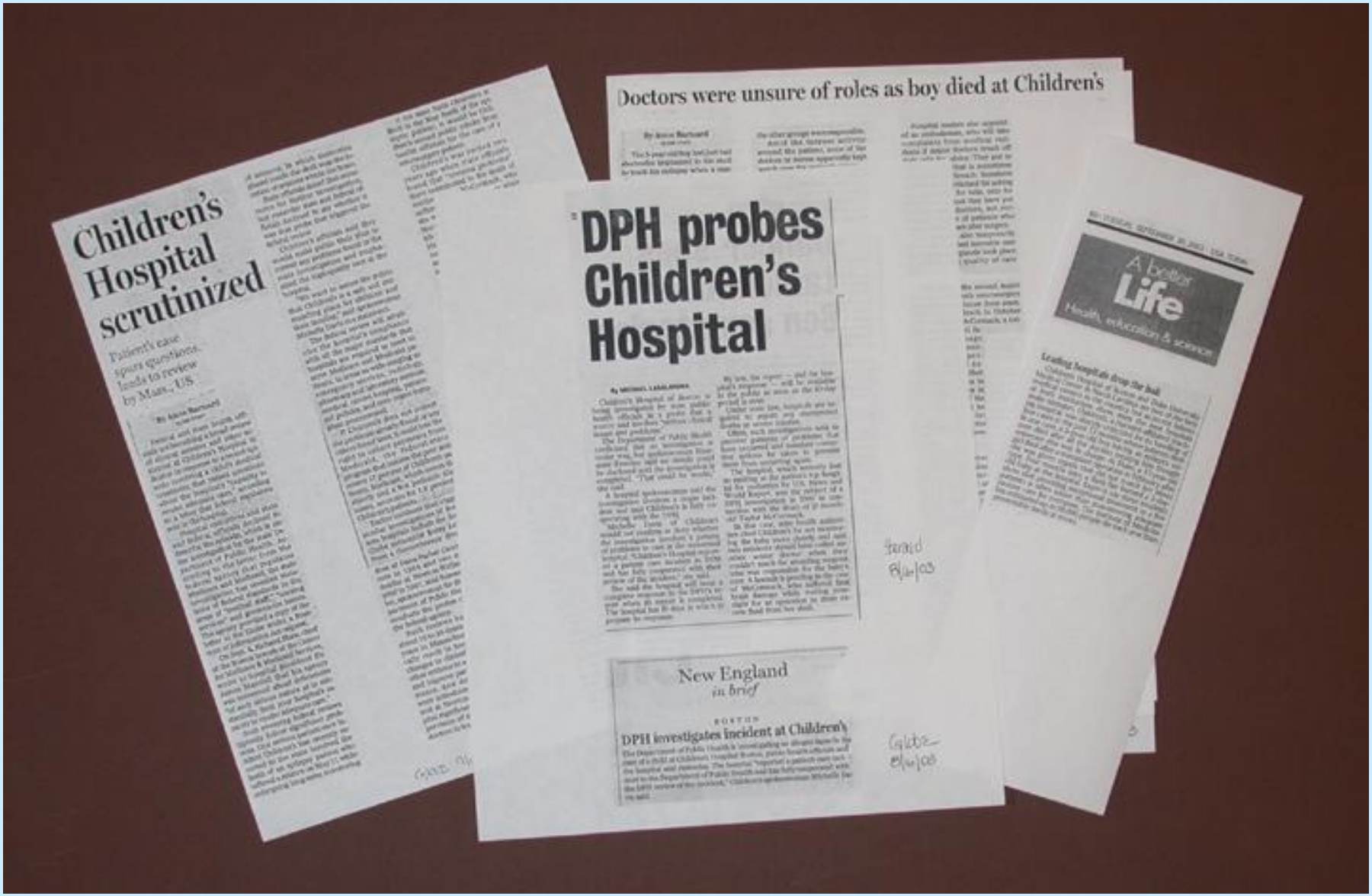
Sequence of Event Management
September, 2003



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



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.

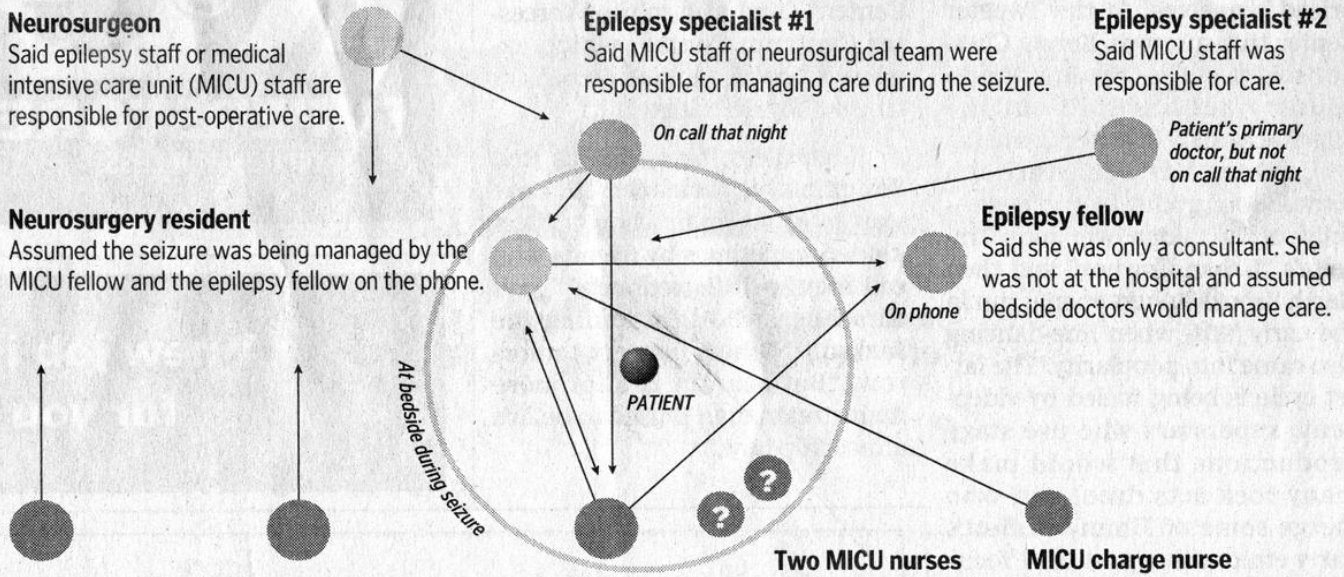
WHAT HAPPENED TO THE PATIENT

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

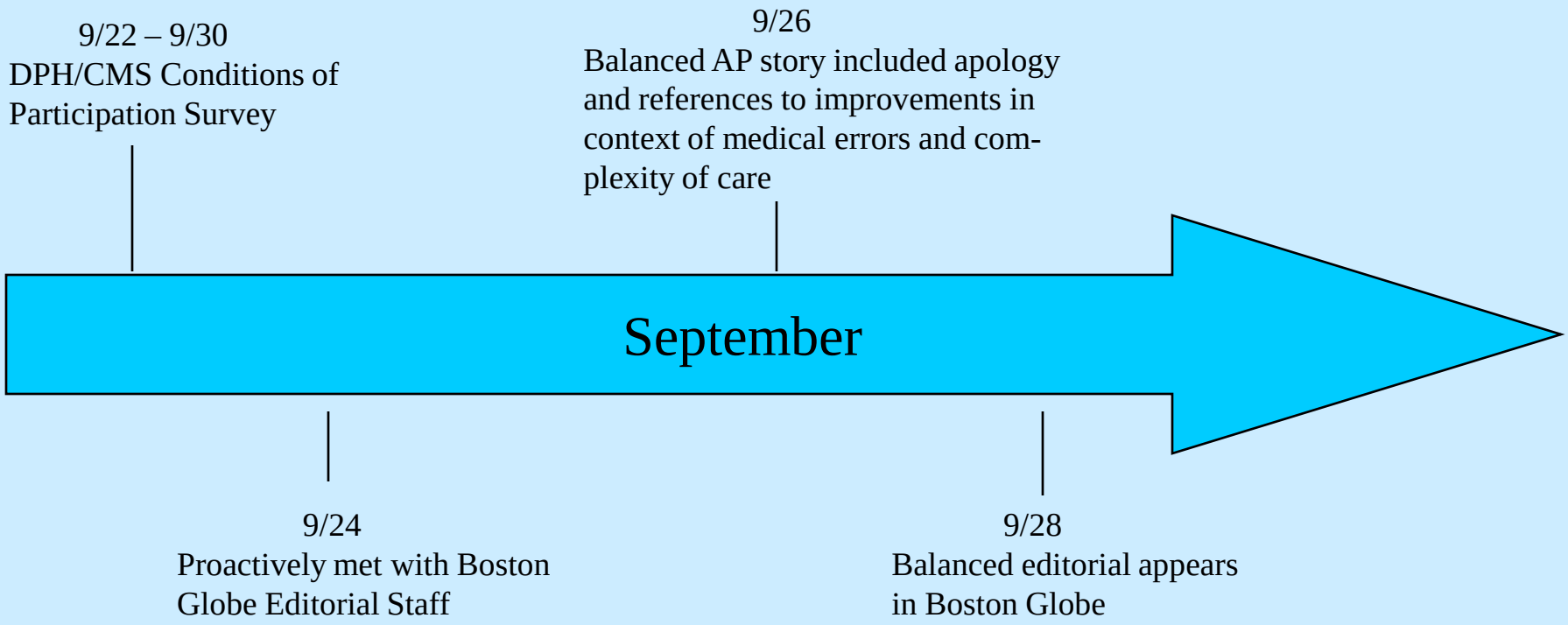
Both doctors at the scene and those in supervisory roles told federal investigators that other individuals or departments were responsible for managing the patient's treatment during the seizure. The patient did receive anti-seizure drugs, but not in high enough dosages.



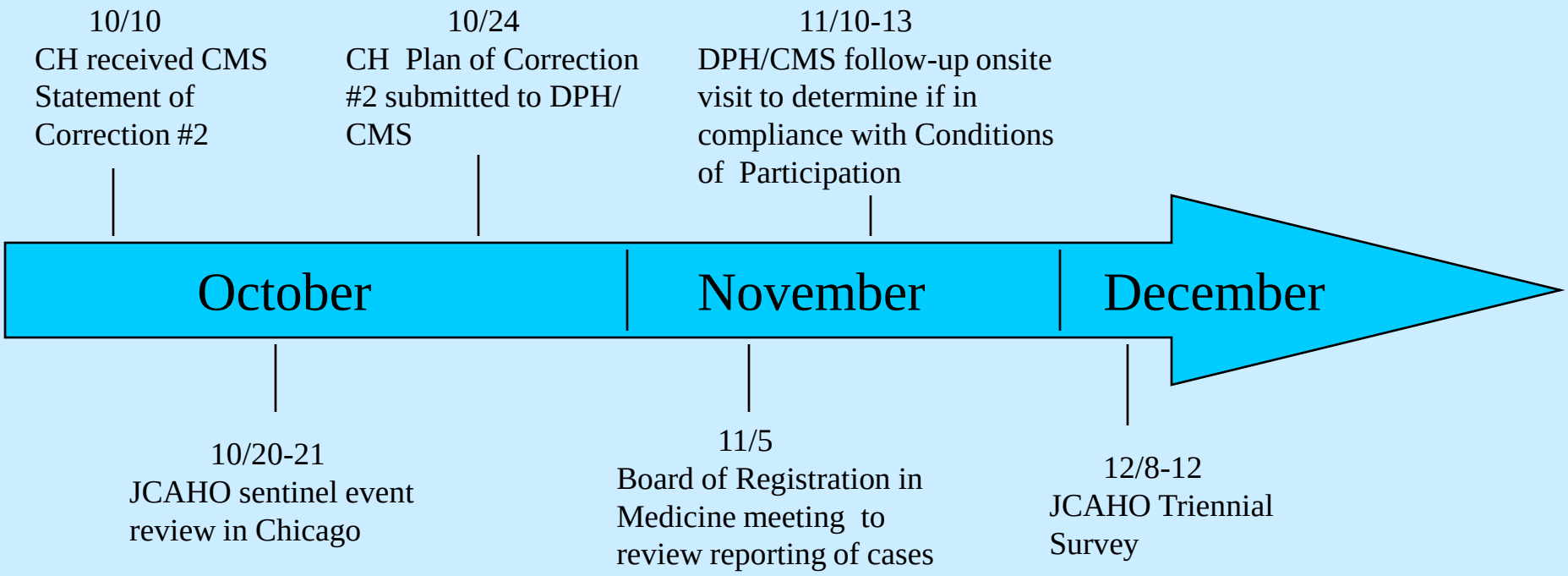
GLOBE STAFF GRAPHIC / SEAN McNAUGHTON

Boston Globe, September 19, 2003, pA24

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

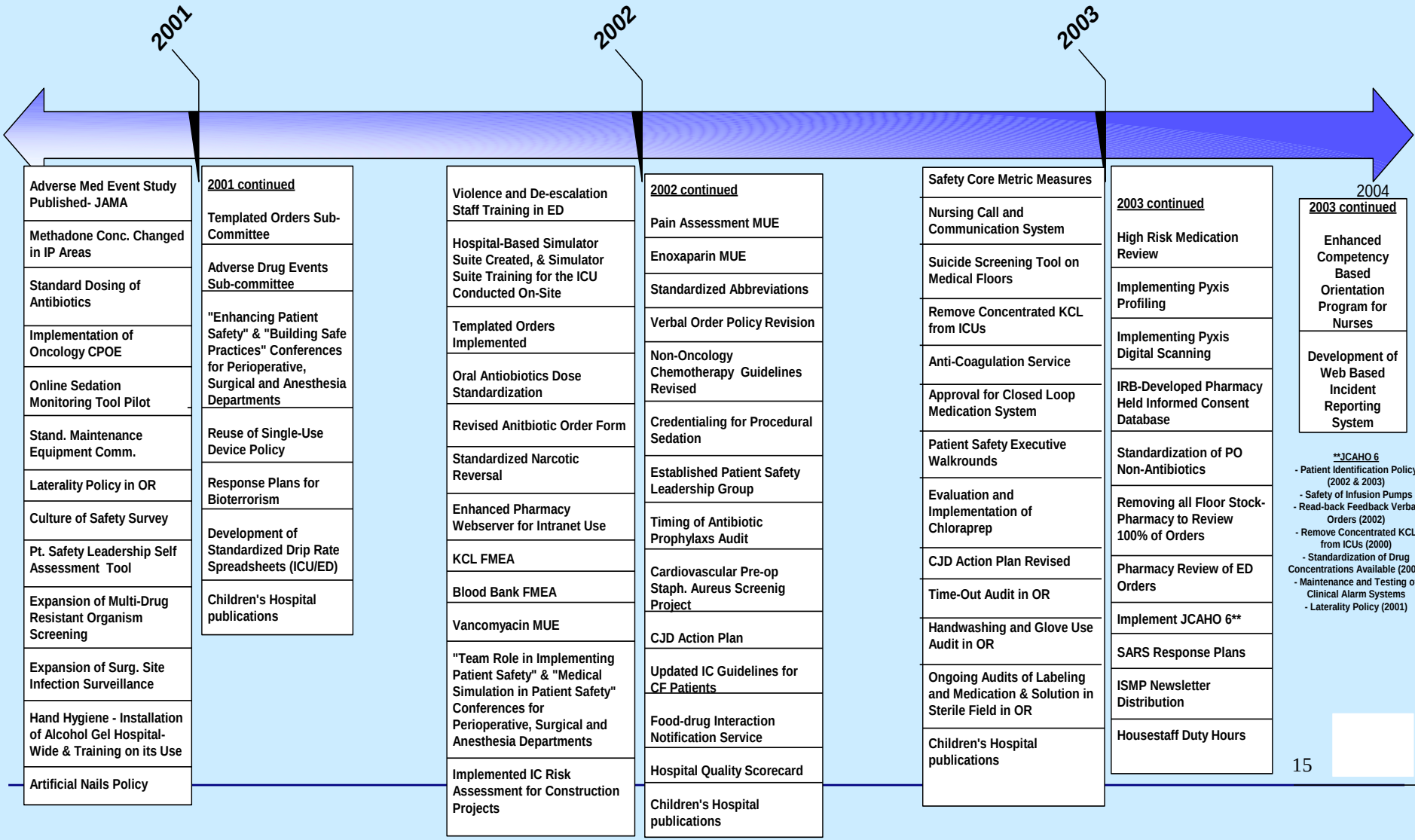
- Failure to Act - Committees established post-review of 2 adverse events in 2002 with recommendations. Diligent, focused implementation of recommendations not pursued fast enough

- 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

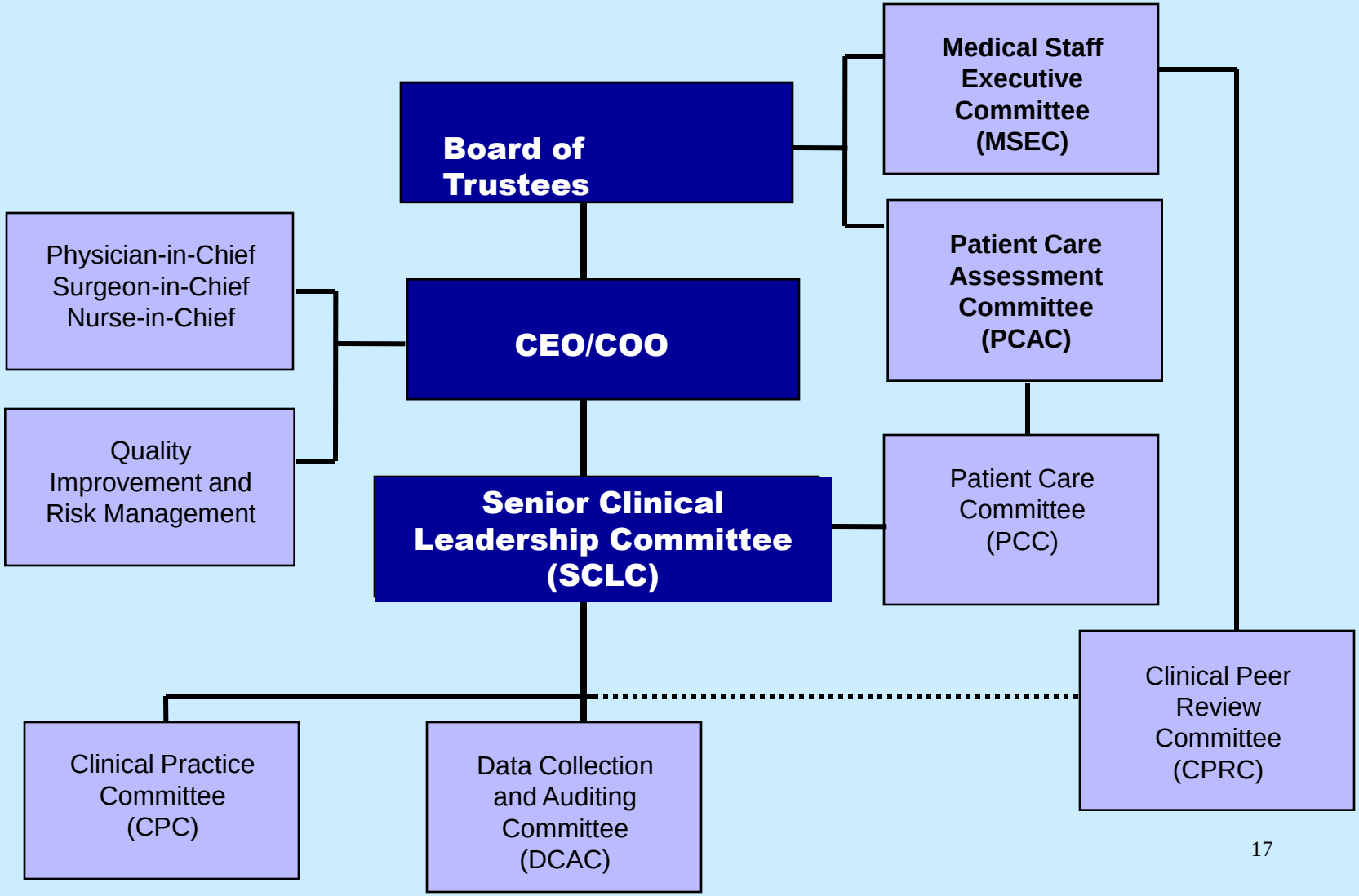
Patient Safety Initiatives 2001-Present



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.	G
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.	G
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.	G

Plan of Correction Critical Success Factors

1. Associate Attending Physician Policy

	Current	Previous	Change	Data Frequency	Status
Number of patients with underlying medical problems identified					
Number of cases presenting with an associate attending					
Number of cases for which associate attending became involved as a result of this policy					

2. Clinical Consultations (actual metrics pending feedback from Data Auditing Compliance Committee)

	Current	Previous	Change	Data Frequency	Status
Metric #1					

R *Insufficient Progress*

Y *In Process - substantial Movement to implement*

G *Completed / Established*

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!