AMERICA'S ESSENTIAL HOSPITALS

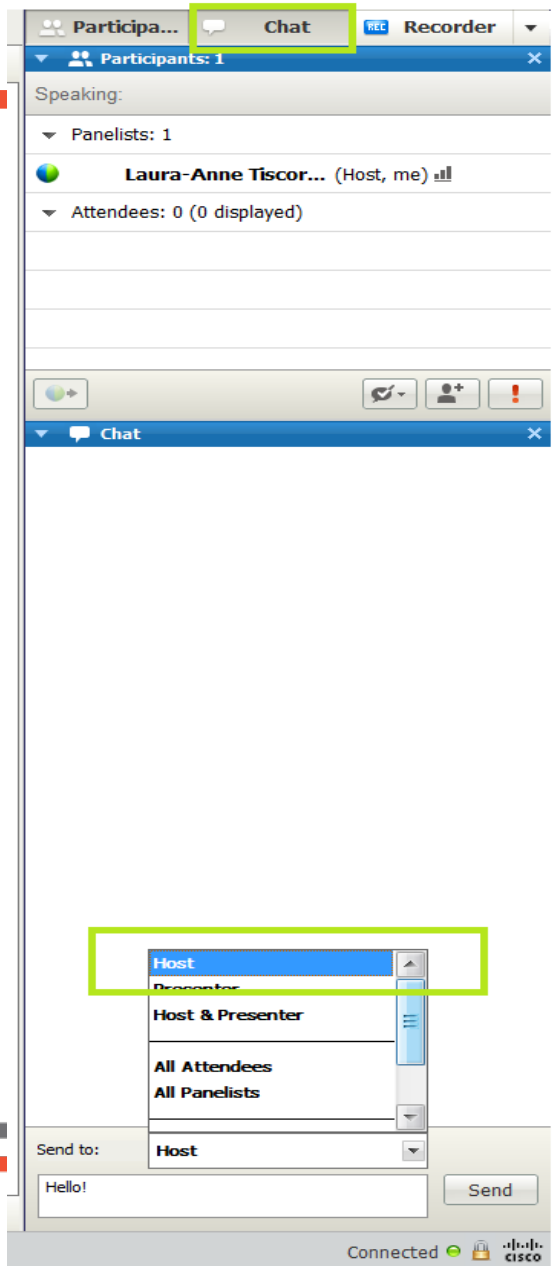
Leadership for Safety: Responding to Patient Safety Disasters

Essential Hospitals Engagement Network

December 4, 2014

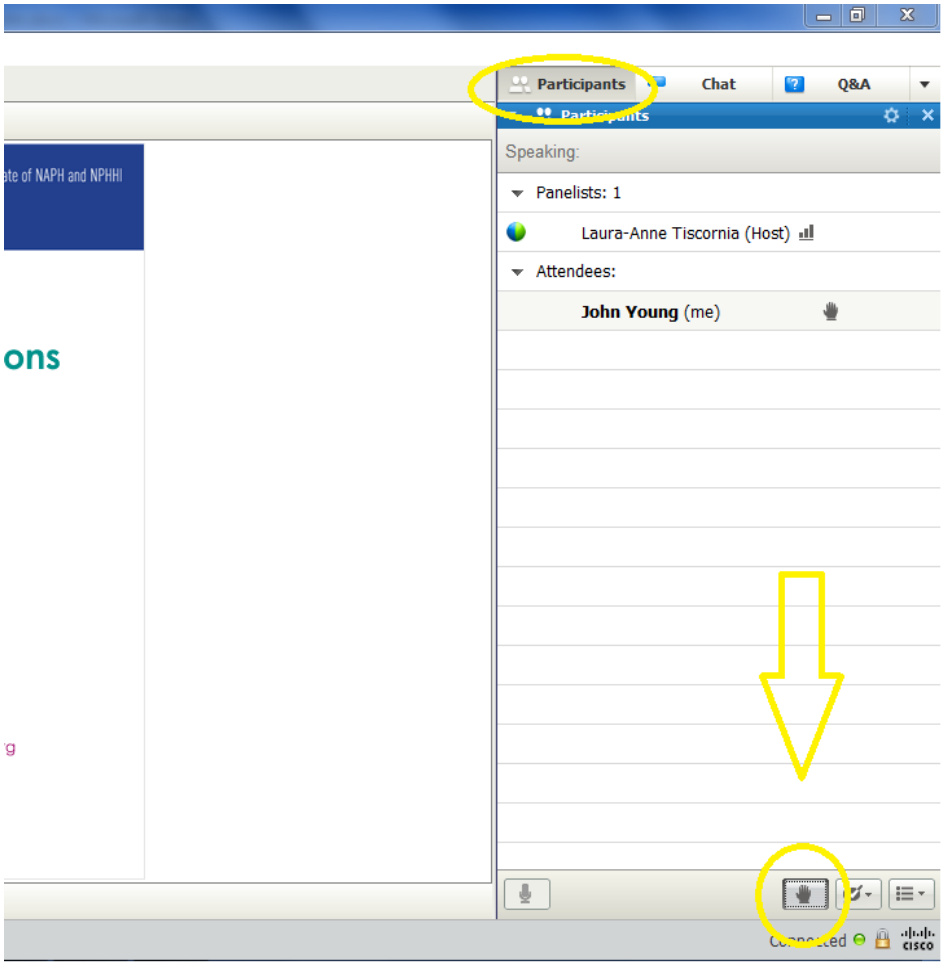
CHAT FEATURE

The chat tool is available to ask questions or comments at anytime during this event.

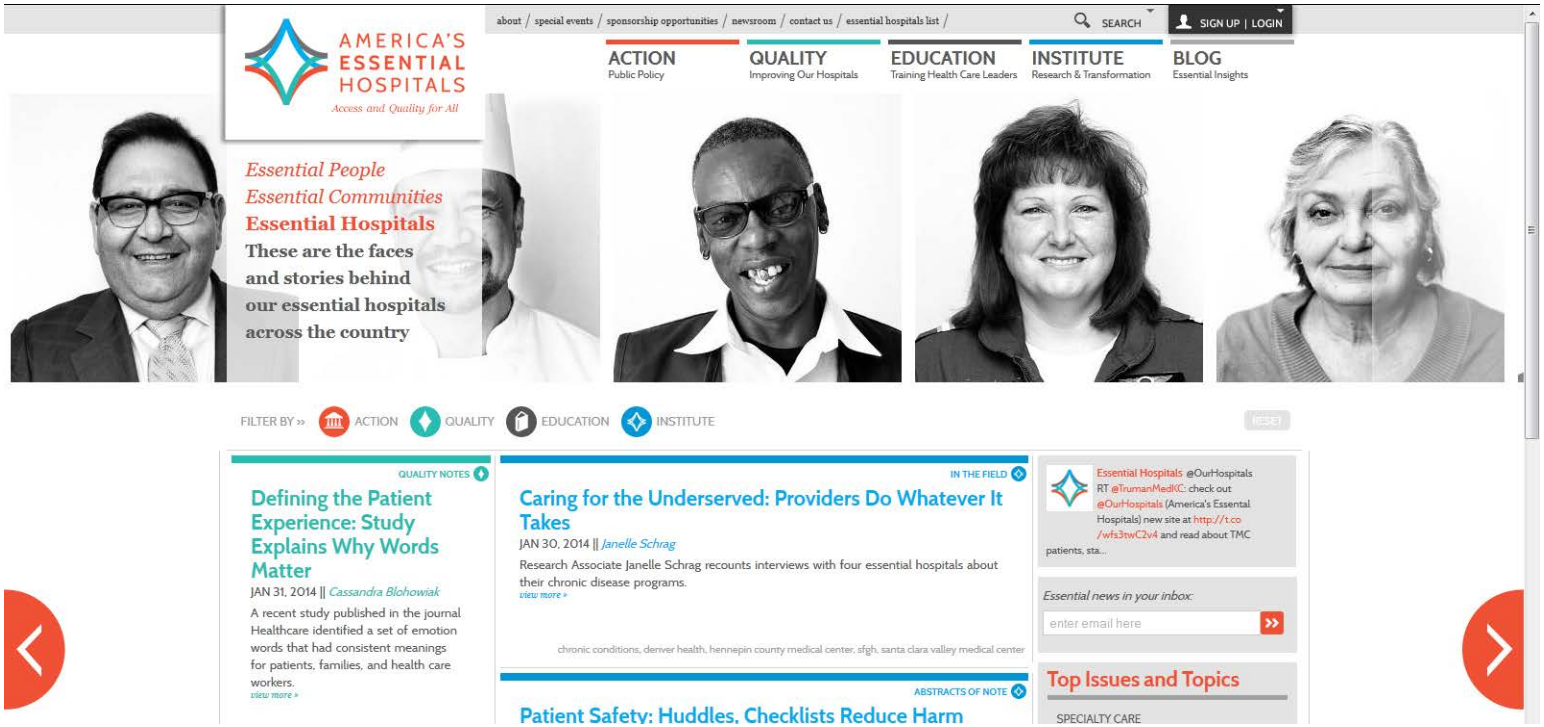


RAISE YOUR HAND

- If you wish to speak telephonically, please "raise your hand". We will call your name, when your phone line is unmuted



ENGAGE AT OUR NEW WEBSITE!



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RESPONDING TO PATIENT SAFETY DISASTERS

America's Essential Hospitals Leadership for Safety Webinar Series

James L. Reinertsen, M.D.

jim@reinertsengroup.com

307.353.2299

Management of Serious Clinical Adverse Events

America's Essential Hospitals
EHEN Leadership Webinar Series
James L. Reinertsen, M.D.
jim@reinertsengroup.com
307-353-2294

Acknowledgement

- Jim Conway

- Conway J, Federico F, Stewart K, Campbell M. *Respectful Management of Serious Clinical Adverse Events (Second Edition).* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

What are we talking about?

- ***Clinical adverse events with permanent psychological and/or physical harm or death to one or more patients.*** Often, but not always, these may fall under the categories of
  - Sentinel Events
  - NQF Serious Reportable events
  - Serious Safety Events (SSE)

I’m sorry to disturb you, but…

Think about your most recent serious adverse clinical event.

How did it go? (for patient/family, staff, organization, yourself)?

What did you learn?

Will you do better next time?

What distinguishes organizations that handle these events well…

- Board and executive leadership in a good safety culture
- A strong plan, well-rehearsed
  - Balanced priorities: patient/family, staff, organization
  - Empathy, disclosure, support (including reimbursement), resolution (including compensation), learning, and improvement

In a Strong Safety Culture…

- You are less likely to have an event
- Leaders are more likely to hear about an event, more quickly
- Senior leaders are more likely to take a visible role in managing a safety event crisis
- The processes of disclosure, support, assessment, resolution…are more likely to be done with empathy and balance

Crisis Management Plan

- Internal notifications
- Crisis Management Team (CMT)
- Priorities
  - Patient and family
  - Staff
  - Organization
    - External and Internal Communications
- External notifications and unannounced visits

Checklist
(From Appendix A, IHI White Paper)

- Internal notification:
  - Board, CEO, Risk Mgmt., PR, Legal…
- Threshold met for activation of CMT?
- Patient/Family
  - Who is the 24/7 contact?
  - Have we expressed empathy and regret?
  - Have we done a full clinical assessment?
  - Are we providing ongoing support and reimbursement?
  - Have we invited family to RCA?
  - Have we stopped “normal communications” that might cause pain?

Checklist, contd.

- Staff
  - Has personal safety of staff been assessed?
  - Have we expressed empathy, been visible to staff?
  - Who is 24/7 contact for staff at sharp end?
- Organization
  - Is there a danger to other patients?
  - Has billing been stopped?
  - Who is on point for communications?
  - Are there required notifications?
  - Are there other organizations that would benefit from knowing about this event?

Seeking To Achieve for All Patient, Family, Staff, Organization

- Empathy
- Disclosure
- Support
  - including reimbursement
- Assessment
- Apology
- Resolution
  - Including compensation
- Learning
- Improvement

A stiff apology is a second insult.
GK Chesterton

If you take my pen, and say you are sorry, but don't give me the pen back, nothing has happened.
Bishop Desmond Tutu

The PR Death Spiral

- A serious event occurs
- The organization is not transparent (internal or external)
- Family or staff, frustrated, contact the media
- Media calls hospital, gets “No comment”
- Media start looking for any scraps of information
- Media gets info from people who don’t really know
- Patient, family, staff, organization traumatized by sensational publicity based on inaccurate info
- The organization’s response to the event becomes a bigger story than the event itself

Poll: Does Your Organization / Practice Have A Crisis Plan?

1. Yes, and uses it
2. Yes, but doesn’t use it
3. No
4. Don’t know
5. Not applicable

What to Do When a Crisis Occurs, Without a 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 patient, family, staff, organization.

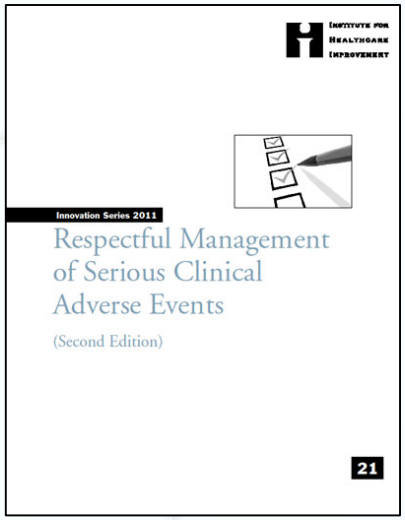
Learning From Events In Other Organizations: Could It Happen Here?

http://www.ihi.org/knowledge/Pages/Publications/CouldItHappenHereLearningfromSafetyEfforts.aspx

An IHI Resource Center

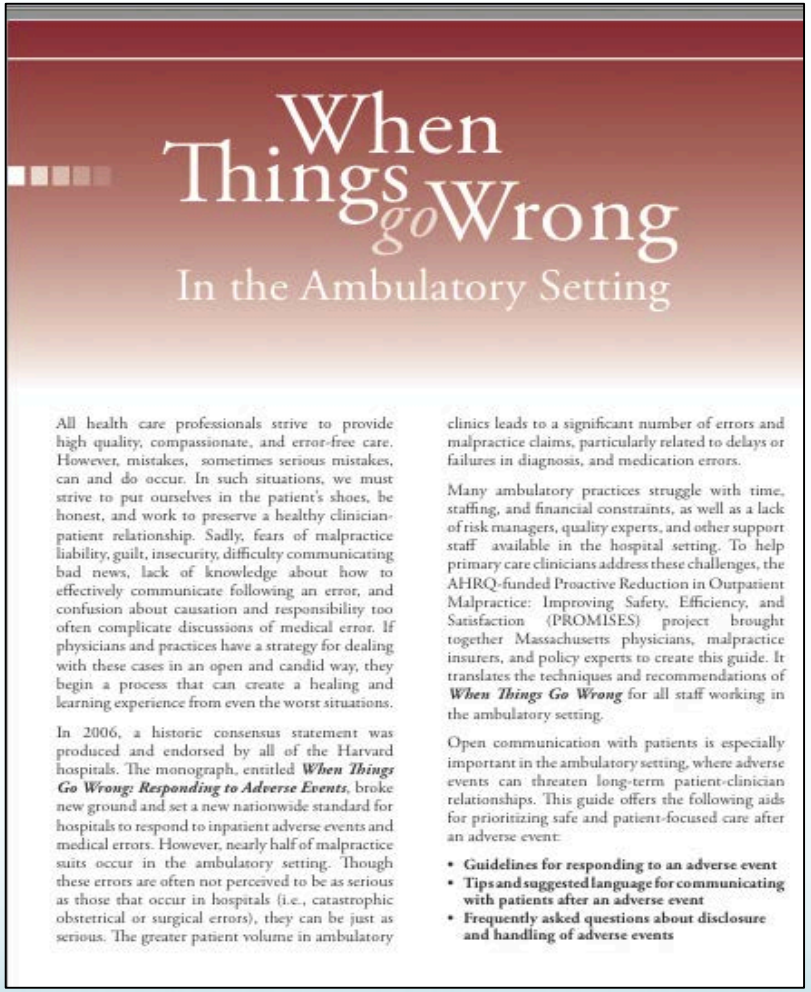
Leadership Response To A Sentinel Event: Respectful, Effective Crisis Management

http://tinyurl.com/IHIEffectiveCrisisMgmt



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

From the Promises Project



When Things go Wrong

In the Ambulatory Setting

All health care professionals strive to provide high quality, compassionate, and error-free care. However, mistakes, sometimes serious mistakes, can and do occur. In such situations, we must strive to put ourselves in the patient's shoes, be honest, and work to preserve a healthy clinician-patient relationship. Sadly, fears of malpractice liability, guilt, insecurity, difficulty communicating bad news, lack of knowledge about how to effectively communicate following an error, and confusion about causation and responsibility too often complicate discussions of medical error. If physicians and practices have a strategy for dealing with these cases in an open and candid way, they begin a process that can create a healing and learning experience from even the worst situations.

In 2006, a historic consensus statement was produced and endorsed by all of the Harvard hospitals. The monograph, entitled ***When Things Go Wrong: Responding to Adverse Events***, broke new ground and set a new nationwide standard for hospitals to respond to inpatient adverse events and medical errors. However, nearly half of malpractice suits occur in the ambulatory setting. Though these errors are often not perceived to be as serious as those that occur in hospitals (i.e., catastrophic obstetrical or surgical errors), they can be just as serious. The greater patient volume in ambulatory clinics leads to a significant number of errors and malpractice claims, particularly related to delays or failures in diagnosis, and medication errors.

Many ambulatory practices struggle with time, staffing, and financial constraints, as well as a lack of risk managers, quality experts, and other support staff available in the hospital setting. To help primary care clinicians address these challenges, the AHRQ-funded Proactive Reduction in Outpatient Malpractice: Improving Safety, Efficiency, and Satisfaction (PROMISES) project brought together Massachusetts physicians, malpractice insurers, and policy experts to create this guide. It translates the techniques and recommendations of ***When Things Go Wrong*** for all staff working in the ambulatory setting.

Open communication with patients is especially important in the ambulatory setting, where adverse events can threaten long-term patient-clinician relationships. This guide offers the following aids for prioritizing safe and patient-focused care after an adverse event:

- **Guidelines for responding to an adverse event**
- **Tips and suggested language for communicating with patients after an adverse event**
- **Frequently asked questions about disclosure and handling of adverse events**

http://www.macrmi.info/files/8113/9230/6584When_Things_Go_Wrong_in_the_Ambulatory_Setting.pdf

Field Opportunities & Challenges

- Converting openness and honesty from a value to ongoing action
- Communicating: what, when, to who, for how long
- Extent of transparency: how broad and deep
- Approach consistency: level of harm
- Burden: liability threat & med-mal reform need
- External review: high value, complex timing
- Training: At every level, the need for and power of training
- Second victim: Includes quality & safety staff

"When something goes wrong it is how the organization acts that redefines and reshapes the culture."

J. Clough, CEO, Mt. Auburn Hospital

Comments, Questions, Answers

UPCOMING EVENTS

- Steering Council Call
  Dec 11 | 2 pm EST

- Ask Every Patient REAL webinar
  Jan 15 | 1 pm EST

- In Person Event:
  Policy Assembly
  Dec 8-9 | Washington D.C.

THANK YOU FOR ATTENDING

- **Evaluation:** When you close out of WebEx following the webinar, an evaluation will open in your browser. Please take a moment to complete. We greatly appreciate your feedback!

- **Check out the new EHEN Leadership for Safety Program website:** http://essentialhospitals.org/institute/ehen-leadership-safety-program/

Visit http://essentialhospitals.org/groups/ehen/ to collaborate today.