The News is Devastating. ***It's My Worst Nightmare.*** *Now, What Do I Do?*

RESPECTFUL EFFECTIVE CRISIS MANAGEMENT

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"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 NR. Managing the Crisis You Tried to Prevent

Outline

- Background
- Leadership
- Focus
  - Patient & Family, Staff, Organization
- Crisis Management Team
- Root Causes Analysis
- Communications
- Crisis Management Plan
- Special Circumstances
- References and Bibliography

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“Mary, I’m sorry to disturb you. We have a terrible problem.”

Evening Administrator-on-Duty

Realities of a Large Complex Imperfect Organization

- Preventable serious harm, medical error
- Fatal rare complication
- Violent crime
- Fire
- Drug diversion
- Identity theft
- Etc.

Endless Opportunities in One COO's Career

- Lehman Chemotherapy Overdose
  - at 1, 2, 3, 5, 10 and years
  - Litigation from staff member
  - Disciplinary actions against clinical staff
- Identity fraud
- Stolen medical records
- Critical incidents and near-misses

Learning from Courageous Handling of Tragic Events by Others

- BIDMC, Boston: Wrong-Sided Surgery
- Catholic Health Partners. Preventable death
- Children's Hospital Boston: Clinical Adverse events
- Children's Hospital San Diego: Sexual abuse by employees
- DFCI, Boston: Chemotherapy Overdose, Identity Fraud
- Duke University Medical Center: Clinical adverse events
- Immanuel St. Joseph's—Mayo Health System: Drug Diversion
- Mt. Auburn Hospital, Cambridge: Aberrant behavior, Credentialing
- Novant Health, MRSA in the NICU
- NYHHC, New York: Death in Psychiatric ED
- Virginia Mason Medical Center Seattle: Adverse events
- Winchester and Eastleigh Healthcare NHS Trust

The First Step: Activate Your Crisis Management Plan

No Plan: Lets keep going and we will come back to the plan.

Case Study:
Serious Medical Error

"We just operated on the wrong side of the brain of Mr. Wall"

How To Respond?

- What should we do?
- Who should do it?
- What should we say, and to whom?
- Whose problem is this?

Whose Problem Is This?

1. Board of Trustees (Governing Body)
   – Are 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

   (more to follow)

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Areas Requiring Focus

1. Patient and family
2. Staff, particularly those at the sharp end of the error
3. Organization

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Patient and Family

- Team disclosure
- Statement of sorrow
- Apology
- RCA participation
- Support
- Resolution
- Learning
- Never lose sight of the patient and family

Never Lose Sight of Patient and Family

- State what happened, why it happened, and what's being done to prevent it from happening again
- Say you're sorry and apologize when appropriate
- Appoint a staff member point of contact 24/7
  - As soon as you know, the patient & family should know
  - Never let them meet a wall, feel a distancing, body language
- Address issues ASAP—Respect & time crucial
  - Take risks in the name of the patient and family
  - Don't let things be unresolved if they can be resolved
- Public statements should begin with sorrow, statements of empathy, resolve, and repentance

For most patients, errors don't erode trust. The way you act after them can.

J. Conway

DFCI Learning

Staff

- Support
- Engage in RCA
- Bring to resolution
- Assure learning
- Never lose sight of the staff at the sharp end of the error

Never Lose Sight of Staff

- Don't jump to conclusions
  - "We'll figure this out together"
  - Be fair and just
- Appoint a staff member contact 24/7
- Provide support immediately and into future
  - EAP and other supports
- Keep an eye out
  - Harm & near-harm can have devastating effects on staff
  - Some staff can be supportive and others damaging
- Address issues as soon as they arise

Organization

- Visible CEO & C-suite engagement ("I care," "I'm accountable")
- Issue a call to action grounded in values, integrity, doing the right thing
- Activate crisis management team and leader
- Notify: Board of Trustees, relevant regulatory agencies
- Activate a root causes analysis (RCA)
- Assume nothing stays confidential
- Prepare internal and external communications
- Never lose sight of patient, family, staff, community
- Don't panic
- Don't waiver—even when it gets very hard

Seven CEO Attitudes Effecting Crisis Response & Making Matters Worse

1. What crisis?
2. No one will find out.
3. It will blow over.
4. I will handle it.
5. Our attorneys will handle it.
6. I'm unavailable.
7. The media is out to get us.

?8: I've dealt with bigger problems than this!

Gladstone J. Executive Decision: Persuading CEOs to do the right thing during a crisis.

A Leader In A Crisis Responds To The Crisis

- Turning fear into positive action
- Being vigilant—watching for new developments and recognizing the importance of new information
- Maintaining focus on the priorities— ensuring that people are safe first and then assessing the next most critical needs
- Assessing and responding to what can be controlled and ignoring what cannot

Managing A Crisis. Harvard Management Update.

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"I am accountable for those unnecessary deaths in our NICU"

Paul Wiles

CEO, Novant Health

Crisis Management Team: Moving Forward

- Routine check-in daily to multiple times a day
- Engage outside help through colleagues and consultants
- Listen and be prepared to hear things you don't want to
  - Include a devil's advocate
- Embrace speed and flexibility
- Stay close to internal and external voices
- Imagine the worst and mitigate as possible
  - Most times it doesn't happen; sometimes it does
- Communicate up, down, and all around
- Be prepared for inquiry from or the arrival of external accrediting and regulatory agencies

"Dig where you stumble; that's where the treasure is."

Joseph Campbell

Model Crisis Management Team

- CEO/COO
- CMO
- CNO
- Communications Officer
- General Counsel
- Patient Representative
- Representatives from: Risk Management / Quality Improvement / Patient Safety
- Relevant service chief
- Others as appropriate for incident

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.

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Internal and External Communications

- What can we say?
- How can we say it?
- Who are we communicating to?
  - External
  - Internal

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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

What Can We Say: Essential Words Compassion, Concern, Empathy, Remorse

Situation Based

Alarmed	Humiliated	Tragic
Appalled	Let you down	Unfortunate
Ashamed	Mortified	Unhappy
Concerned	Regret	Unintended
Disappointed	Sad / Saddened	Unnecessary
Embarrassed	Shocked	Unsatisfactory
Empathized	Sorrowful / Sorrow	
Failed / Failure	Sympathetic	

Lukaszewski J. Establishing Individual and Corporate Crisis Communications Standards

What Can We Say Essential Messages

- **Excellent organization and staff but not perfect**
  - We come to work every day to close the gap
- Everyone is committed to quality care and safety
  - Trustees, leaders, clinicians, and all other patient care staff
  - We must put in systems that support safe care
- Humbled and confident we are working hard to minimize the risk of errors going forward
- Utilize this tragedy to take this organization to a transformed place for our patients, family, staff, and community

What Can We Say?

- Communications and Legal must be flexible
- Don't hide—you must engage the process
  - Early information is often incorrect
  - Misinformation fills a vacuum - very hard to correct later
  - Credibility essential - Never speculate
  - Good information drives out bad
  - The first news stories frame everything
  - Get continual updates

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

Communications Priorities

1. Those most directly affected
   – Victims, intended and unintended
2. Employees
   – Sometimes they can be victims too
3. Those indirectly affected
   – Neighbors, friends, families, relatives, customers, suppliers, government, regulators, third parties
4. The news media and other channels of external communications

Lukaszewski J. Establishing Individual and Corporate Crisis Communications Standards

Who Are We Talking To?

- Patients, staff, trustees, regulators, supporters (donors, community leaders, local officials), interested parties (insurers, etc.)
- Don't let your core constituencies learn everything from the news media – communicate directly
  - Email, twitter, other social media have changed EVERYTHING
- Many people want and need to believe in you – make that possible
- Use all your tools to provide regular updates
  - personal calls, e-mail, fax, websites, letters, social media

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.

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Special Circumstances

- Appendix
  - Guidelines for Disclosing Medical Error Affecting Multiple Patients
  - Learning from Events in Other Organizations

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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

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

Don’t Make It Up as You Go Along
Policies, Procedures, Process Flows

- Develop policies and procedures to support:
  - Reporting
  - Communications
  - Disclosure
  - Support
  - Resolution
  - Learning

IHI. Communicating After An Adverse Event

Crisis Preparations Survey of Fortune 500 CEOs

89%	Crises are inevitable
50%	Have crisis management plans
97%	Confident crisis will be well managed

How about healthcare?

- Are we confident?
- Do we have a plan?

Fink S. Crisis Management

Never lose sight of the patient, family, staff, organization, and community.

And for the rest of us in the healthcare community watching from afar…

Offer support, a helping hand, counsel to others dealing with tragic events and crises.

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

J. Clough, Mt. Auburn Hospital

An IHI Resource Center

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

http://tinyurl.com/IHIEffectiveCrisisMgmt

Appendix

Proposed Steps To Address A Medical Error Affecting Multiple Patients

- Identify the error in a timely fashion.
- Conduct a review of an appropriate sample of records or procedures to determine the extent of the error.
- If a full review is necessary, identify a project team, establish the scope of the review and determine the resources needed for the review.
- Identify patients who may have been affected by the error and include their records in the review.
- Review clinical records…for appropriateness of care
- Inform patients and other stakeholders Affected patients need to be followed up by the physician who has been most closely involved in managing their care.

Chafe R, Levinson W, Sullivan T. Disclosing errors that affect multiple patients, CMAJ. May 26, 2009.

Proposed Guidelines For Disclosing A Medical Error Affecting Multiple Patients

- After an error has been confirmed, it should be disclosed in a timely manner, even if its extent or full impact is not yet clear.
- Initial disclosure should not identify individual clinicians or include assumptions about cause.
- All patients who may have been harmed by the error should be followed up individually.
- A communications plan should be established that includes mechanisms (e.g., a dedicated phone line or website) for affected patients to gain access to information and ask questions.
- Affected patients should be given priority over current patients when appropriate.
- An analysis of the root cause should be conducted and led externally.
- The results of the analysis should be released publicly with statements of the actions undertaken to address problems identified.
- A clear and fair process should be used to evaluate the performance of clinicians involved in the adverse event.

Chafe R, Levinson W, Sullivan T. Disclosing errors that affect multiple patients, CMAJ. May 26, 2009.

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Learning From Events In Other Organizations

- Set an expectation
- Establish a system to learn of events
- Agree on the focus
- Develop reliable sources and get the facts straight
- Ask yourself: could it happen here?
- Ask yourself again: could it happen here?
- Listen and learn
- Take notes on the oganization’s response
- Tell your story internally
- Tell your story externally

Conway J. Could It Happen Here?

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