First, Do No Harm
Part 2: Taking the Lead

Expanded Facilitator's Guide

RMF

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Partnership for Patient Safety

RISK MANAGEMENT FOUNDATION
HARVARD MEDICAL INSTITUTIONS

First, Do No Harm
Part 2: Taking the Lead

"Safety is not a set of rules. It is created by the people at the front lines as they come to work everyday."

—Eric Knox, MD, Director of Patient Safety
Children's Hospitals and Clinics, MN

"We are moving forward as an industry in doing miracles. So the risk is rising, the bar is rising, almost as a consequence of progress, and that calls for us to develop new strategies to manage the risks."

—Martin J. Hatlie, JD, President
Partnership for Patient Safety

"Safety has to become part of the organization's fabric."

—Kevin Roberg, Board of Trustees Member
Children's Hospitals and Clinics, MN

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Introduction

First, Do No Harm, Part 2: Taking the Lead (FDNH2) was developed as a sequel and a companion piece to an earlier video, *First, Do No Harm*. Released in 2000 by Risk Management Foundation of the Harvard Medical Institutions (RMF) and the Partnership for Patient Safety (p4ps), the first film was a composite case study derived from three closed malpractice claims managed by the Controlled Risk Insurance Company (CRICO)[1]. The principal objective of *First, Do No Harm* was to engender discussion about a systems-based approach to safety in health care and the ways in which small systems failures can combine to produce serious, adverse patient events.

FDNH2 was created to further those discussions by examining the responses of one health care system to the events portrayed in the original film. This program is a dramatized case study. It is not intended to model best practices. Instead, it portrays the way one hospital might re-examine its culture and typical practices in response to a sentinel event. The objective of *FDNH2* is to stimulate dialogue and serve as an interactive tool you can use to assist your organization to become more systems-based and patient-centered.

The developers of *FDNH2* emphasize that this interactive video is not designed to be a "how to" formula for any organization. Although the developers of *FDNH2* drew upon the experiences of many people responding to sentinel events, the behaviors portrayed do not always demonstrate best practices. Rather, the intention is to use a dramatized case based on actual facts to stimulate discussion in several areas, including:

- Recognizing and addressing systems issues that undermine optimal patient safety.
- Assigning accountability for improvement.
- Examining the potential roles of health care organization executives.
- Governing board members, clinical leadership, and frontline health care workers.
- Placing the patient at the center of our work.

We know that the delivery of health care is highly complex and dynamic, and therefore intrinsically prone to failure. We know that other high-risk industries have worked hard to embed a systems approach to managing the risks of human injury into their cultures. We know that we can learn from those industries and can adapt some of their lessons to patient care issues. We also know that health care is unique in many ways. Accordingly, we recognize the need to expand the dialog about patient safety within the health care sector as well as in other fields so that we continue to learn from and support each other.

[1] The Controlled Risk Insurance Company (CRICO) provides professional and general liability insurance for the Harvard-affiliated health care organizations. The circumstances depicted in FDNH, while derived from actual cases, have been modified to ensure the privacy of the patients involved and to comply with federal and state law.

Overall program objectives of video:

- To provide examples of how organization's executive and clinical leaders, governing board members, and frontline health care professionals can set the agenda for patient safety.
- To provide useful examples of systems problems that will stimulate discussion of opportunities for improvement.
- To discuss the balance between individual accountability and organizational accountability for patient safety.
- To address organizational culture issues that may contribute to medical error and patient injury and suggest steps that can lead to cultural change.
- To identify organizational barriers to improvement.
- To heighten clinicians' self-awareness of their crucial day-to-day roles in creating organizations that are safer and truly patient centered.
- To facilitate identification of significant breakdowns or gaps in the care continuum.
- To transfer knowledge of core characteristics from other industries and organizations that deliver highly reliable services.
- To focus attention on the practical application of systems theory through case-based learning.
- To acknowledge and honor the emotional and physical toll on patients and families, as well as health care providers, when preventable patient injuries occur.
- To stimulate the re-examination and refinement of strategies for reducing malpractice litigation risks.
- To stimulate discussion about the disclosure of unanticipated events.

Examples of learner-centered objectives:

After viewing the video and participating in the discussion, the participant should be able to:

- Describe the role of leadership in developing a culture of safety.
- Identify actual and potential system failures that contributed to suboptimal care.
- List some short- and long-term goals to address identified system flaws.
- Discuss how changing the culture will facilitate reporting and identifying system failures.
- Identify teamwork and communication issues that contributed to less-than-optimal care.
- Discuss ways to provide support for providers who are involved in medical errors.
- Suggest ways that patients can be enlisted to help providers prevent errors and identify faulty systems.
- Discuss the issues and challenges associated with the disclosure of unanticipated outcomes.

Preparing for the Session

It is recommended that this video be used as part of a facilitated session. The facilitator's role is to encourage discussion among the group. The premises that underlie this guide are three-fold (1) there is rarely, if ever, just one way to solve a problem; (2) each person that engages in problem solving sees it from his or her own perspective; and (3) everyone's contribution is important in understanding system performance and developing solutions that improve patient safety.

FDNH2 raises many issues. The facilitator can ask the group to discuss the film in its entirety, or to focus on selected sections. When planning, consider the following approach:

1. Meet or talk with the planner or organizer of the session. Discuss any specific objectives the planner may have for the session, using or adapting the objectives listed in the previous section of this guide.
2. Determine and evaluate the composition of the audience and its individual needs. The audience may include:
    - Executive Leadership
    - Managers
    - Board of governance members
    - Clinicians:
        - Physicians only
        - Multi-specialty
        - Specific specialty
        - Mixed professions (nurses, NPs, Pas, CNMs, etc.)

    If possible, it is recommended that each discussion group be a mix of professions and organizational layers. Patient safety is in everyone's job description and requires communication and cooperation across organizational and professional demarcations.
3. Decide whether to contact or prepare any audience member or segment in advance. This preparation is useful if there are sensitive subjects or relationships in the organization that the discussion of the film will likely bring to the surface, or if encouraging selected participants to raise specific issues or questions would improve the discussion.
4. Determine the length of time allowed for the session. It is recommended that the session last at least one hour.
5. Determine whether the space for the session can accommodate the necessary equipment and is compatible with the size of the audience.
6. View the video several times with the above information in mind.
7. Develop appropriate opening question(s).

Using the DVD

The interactive DVD format provides the facilitator and the viewer with a variety of ways to use the program. Sessions may be customized for different audiences, time frames, or objectives.

After inserting the DVD into the player, the following main menu will be displayed: ...

- Play the drama.
- Play the drama and select interview segments at specific points.
- Select a specific scene.
- Select a specific interview segment.

By selecting "Play Drama" and pressing "Enter," the drama will play in its entirety without suggesting breaks for discussion, though it can be paused at any time.

Selecting "Play Video with Interview Segments," will allow you to bring in expert commentary. At five points in the program, an onscreen graphic that reads "Press Enter for Expert Interviews" will appear. Pressing "Enter" will display a submenu listing interview segments that provide expert commentary on issues addressed in that part of the drama. These interview sections can be viewed in whole or part and be paused as desired. To return to the drama, simply select "Resume Program."

To view a single scene, select "Scene Index." A submenu listing each scene by name and pictorial keyframe will be displayed.

Select "Interview Segments" to display a submenu listing each interview segment by topic.

Using the VHS

On VHS, the drama will play in its entirety without suggesting breaks for discussion, though it can be paused at any time. After the drama, expert interviews are organized by topic in the order that the topics appear in this guide. However, the tape must be manually queued to the desired section. Since the counters on VCRs vary from one machine to another, we suggest that you pre-screen on the VCR you will be using, then note the appropriate scene numbers in a copy of your Facilitator's Guide for later reference.

Facilitating the Session

1. Introduce the video.

   Example: This video represents one institution's response to events that produced a serious adverse outcome. These events, originally depicted in FDNH and the basis for the institution's reaction, were developed by drawing from closed medical malpractice cases from the files of Risk Management Foundation of the Harvard Medical Institutions. The cases were selected because they illustrate common and systemic causes of patient harm. The events portrayed are factual, except that three cases have been combined into one and in the film all the events happen to one family.

   This video depicts the meeting where the involved clinicians and the institutional leaders begin the investigation of these events. This video does not present best practice models. Again drawing on actual events, the producers have created this scenario to depict the reaction of the clinicians. It is intended to stimulate discussion. The interactions among the individuals involved demonstrate the tension, uncertainty, fear, and frustration that providers experience when there is an untoward event. By developing, showing, and discussing this video, we hope to assist you in forming an action plan to respond to such events, and begin to change the culture in your institution to one where safety is the number one priority and THE program.

2. Observe the audience watching the video, noting any reactions that may suggest a particular opening question.

3. After the final section ends, leave the audience members in silence for 10-15 seconds to collect their thoughts, either while you let the credits roll or after you've turned off the video equipment following the last section.

4. Lead with the question you chose or acknowledge someone who appears ready to speak.

Examples of Opening Questions:

- Are some of the issues identified in this video similar to those we have in your institution?
- Is this an example of how (y)our institution would react?
- What systems issues did you identify?
- What would you like to hear from the institution if you were Tibor Romanov?
- Choose a section and tell us how you would handle that situation. Put yourself in _____'s place and tell us what you would do next.
- What are some of the conflicts that you identified in these scenes?

- Is this something that you have previously experienced?
  - What part did you play?
  - How did it make you feel?
  - Did you have a choice in how you or others reacted?
  - Was anything corrected as a result?
- Name one problem that you identified that you could personally do something about in your practice setting.
- *Questions for CEO and board members*
  - Do you participate in discussions about patient safety in your organization?
  - Do you think that the board member should have been involved in a meeting such as depicted in this video?
- Do you think that the leadership of your institution is aware of the cultural issues that may be preventing the development of a safe environment?
- What is the role of the clinical leaders in situations such as this?
- Are you addressing the issue that a health care provider like Nurse Jones is a 'second victim' of a system failure? How?

How to Use the Experts' Commentaries

A number of the leaders and experts who have successfully changed the culture and implemented patient safety initiatives within their own institutions have contributed to this video. These commentaries can be used at various stages. They can be used to initiate discussions, as examples of how others have made changes, or to support a point made during the session.[3]

How the Expanded Facilitator's Guide Is Organized

The video is divided into **Scenes A – O**. The scenes are broken out and identified to assist in selecting topics for focus in the session. Some scenes serve to set up or support other scenes and may not lend themselves to individual discussions. At the end of each section in the film, there is a natural break in the drama that provides a good opportunity to pause for participant discussion or use of Expert Interview Segments.

For each scene, this Expanded Facilitator's Guide outlines:

- Description of the action
- Themes
- Learning objectives
- Suggested discussion questions
- Additional resources

[3] See page 3 for suggestions on how to use the DVD or VHS format.

The Characters

Ariana Romanov	Patient
Tibor Romanov	Husband of patient
Betty Jones, RN	OB nurse
Terry McGiver, MHA	Chief Executive Officer
Jack Heath, MBA	Board of directors member, Chair of the Board's Patient Care Committee
Connie Goldman, FASHRM	Risk Manager
Daria Pannessi, MS	Director of Quality Management
Anne Baxter, MD	Obstetrician
Michael O'Leary, MD	Attending OB surgeon
Arthur Beckett, MD	Anesthesiologist
Janet Harper, RN	Head OB Nurse
Douglas Feldman, MD	OB Chief Resident
Sarah Janowitz, MD	Board of Directors member, Chief of Oncology
Rachel Klein, RN, MA	Chief of Nursing
Eric Walcott, JD	Legal Counsel
Stan Wozniak	Investigative Reporter

The Video Scenes

Scene A A montage of events in the case of Ariana Romanov is shown.

Scene B Terry McGiver, CEO, learns that Jack Heath, board member, will be participating in a meeting to discuss the Romanov case.

Scene C Health care providers involved in the care of Ariana Romanov gather to discuss the events.

Scene D Connie Goldman, Director of Risk Management, recaps the case. A heated discussion develops among participants.

Scene E The board member brings the meeting to order in dramatic fashion and sets the tone for the rest of the meeting. He compares the safety issues in health care with those of other high- risk industries and recounts his experience in the airline industry.

Scene F A reporter is trying to contact Tibor Romanov after learning about the events.

Scene G Return to the conference room where the individuals in attendance begin dissecting the case and suggest a first step toward improvement.

Scene H The clinicians discuss the admission to the Labor and Delivery Unit. The concept of the "safety zone" is introduced.

Scene I Dr. Janowitz, Chief of Oncology and board member, implies that this adverse event is an isolated problem and that McGiver, the CEO, should let legal counsel handle communication with the patient/family.

Scene J The participants discuss various communication issues.

Scene K A reenactment of the C-section, with new dialogue reflecting improved interactions among the providers, is shown.

Scene L The meeting participants realize they haven't yet talked to patient/family. McGiver decides it is time to meet with Tibor Romanov.

Scene M Terry McGiver and other members of the team make their way to Ariana's room. Attorney Walcott and Risk Manager Goldman argue about disclosure strategies.

Scene N TO BE REVISED Terry McGiver, Connie Goldman, Director of Risk Management, and Dr. Baxter, Obstetrician, enter Ariana Romanov's room to meet with Tibor. Rachel Klein tries to contact Betty Jones.

Scene O? TO BE REVISED

Section 1: Scenes A-E

Expert Interview Segments following Section 1

1. The Value of Sentinel Events

2. Leadership's Role in Creating a Culture of Safety

3. Learning From Other Industries

(see Program Chart on page 28 for more details)

"I'm not going to. You are."

Scene A: Flashback

Description of the action

Nurse Jones is awakened by a flashback of the events of the Ariana Romanov case. A recap of the case is presented.

The patient, Ariana Romanov, is a late term pregnant woman She speaks very little English, and relies on her husband to translate and communicate for her. The ultrasound results and the expected due date as calculated by her obstetrician differ. She is asked to schedule a follow-up appointment within one week. The secretary is not able to schedule the appointment as requested. Ariana then presents (when??. Need to check this) to the Emergency Department with severe back pain. She is triaged and sent to a busy, understaffed unit. There are decelerations evident on the fetal monitoring strip. Each of the nurses focuses on a specific part of the strip and does not examine the strip as a whole. Nurse Jones has concerns about the patient, and asks the Chief Resident, who has been working for 24 hours, to examine Ariana. He decides to send in a medical student instead, who determines that the fetus is in need of immediate attention. Mrs. Romanov is rushed to an emergency C-section.

During the preparation, the anesthesiologist notes that Ariana has a Class II airway, which means that there may be some difficulty in intubating her. She is given a paralyzing agent. The anesthesiologist continues to struggle with the intubation. The attending obstetrician determines that the fetus is in danger and begins the procedure. In the meantime, the code team is called. The fetus is removed and handed to a pediatrician for immediate intervention. In the process, the newborn receives a dose of methergine administered by Nurse Jones instead of the ordered Vitamin K.

Themes

- The "second victim"

Learning objectives

- Discuss the impact of adverse events or medical errors on clinicians.
- Discuss how the organizational culture could affect the feelings and actions of the "second victim."
- Describe a procedure for caregivers' debriefing after an adverse event.

Suggested discussion questions

- How would (y)our institution deal with Nurse Jones?
- What resources does (y)our institution offer caregivers involved in medical errors?

Additional resources

- Expert Interview Segment #1: The Value of Sentinel Events
- *First, Do No Harm*. www.FDNH.com. (2002).
- Hilfiker, D. 1984. Facing our mistakes. N Engl J Med vol #: 118-122.
- Liang, MK, RN, MN. 1994. Letting the healing begin. AJN vol #: 49-50.

Scene B: McGiver Arrives

Description of the action

This scene introduces Terry McGiver, hospital CEO, arriving at work. He has scheduled a meeting for all involved in the Romanov case to discuss the events and next steps. He is surprised to learn that Jack Heath, a board member and newly appointed chair of the Board's Patient Care Committee, will be attending the meeting. Apparently, Mr. Heath received a telephone call informing him about the Romanov case and the caller's concerns about patient safety at the institution.

Themes

- Role of the board of directors/trustees in an organization's patient safety program.
- Participation of top administration in the investigation of adverse events.

Learning objectives

- Discuss methods of educating board members on procedures for investigating adverse events.
- Describe ways to counteract "the rumor mill" when adverse events occur.

Suggested discussion questions

- How do you (we) learn about serious events at (y)our institution? Who decides what information is shared?
- What is your reaction to Jack Heath's phone call to Terry McGiver?
- Are the board members in (y)our institution as involved as Jack Heath is? Should they be?

Additional resources

- Expert Interview Segment #2: Leadership's Role in Creating a Culture of Safety
- *"Strategies for Leadership. An Organizational Approach to Patient Safety,"* http://www.hospitalconnect.com/aha/key_issues/patient_safety/contents/VHAtool.pdf. 13 Sept. 2002.
- *"Strategies for Leadership: Hospital Executives and Their Role in Patient Safety,"* http://www.hospitalconnect.com/aha/key_issues/patient_safety/contents/conwaytool.pdf. 13 Sept. 2002.
- Covey S. 1991. *Principle Centered Leadership*. NY: Simon and Schuster
- Phillips D. 1992. *Lincoln on Leadership*. Warner Books.
- Pslek, P. and Wilson, T. 2001. Complexity, leadership, and management in health care organizations, BMJ 232:746-749.
- Quinn R. 1996. Deep Change: *Discovering the Leader Within*. Jossey-Bass Publishers.

Scene C: Meeting Begins

Description of the action

This scene introduces the clinicians involved in the care of Mrs. Romanov as well as hospital personnel: administrators, the director of risk management, the director of quality management and the institution's general counsel. A member of the board of directors is an unexpected addition to the meeting. Tension is palpable as the Romanov case is reviewed and contributing factors are discussed. Turf battles, blaming, and defensive behavior are exhibited.

Themes

- Behaviors that may act as barriers to creating a culture of safety.
- Lack of shared responsibility for adverse events.
- Fear of personal and professional consequences in an environment perceived by clinicians to be punitive.
- Lack of trust among the members of the organization.

Learning objectives

- Name behaviors that seem to be counterproductive to creating shared responsibility for patient safety.
- Discuss ways that the involvement of board members may influence patient safety.
- Describe attributes of a physician leader and an administrative leader valuable in creating a culture of safety.

Suggested discussion questions

- Are these typical reactions during a meeting such as this?
- Why do some of the participants feel that patient safety is the “flavor of the month”? Is this an attitude you've come across in (y)our organization?
- Does “patient safety” mean the same to the physicians in the meeting as it does to the administrators?

Additional Resources

- Expert Interview Segment #2: Leadership's Role in Creating a Culture of Safety
- Veteran’s Administration Root Cause Analysis. http://www.patientsafety.gov/tools.html.
- VHA National Patient Safety Improvement Handbook. http://www.patientsafety.gov/NCPShb.pdf.

Scene D: Conflict Arises

Description of the action

As the meeting continues, issues of reporting to regulatory agencies arise causing strong reactions from physicians. The Director of Risk Management continues her efforts to piece together the timeline of the Romanov case, to reassure participants that the meeting is not about blaming anyone, and to facilitate the heated discussion between the OB surgeon and the anesthesiologist. Issues of teamwork are explored. The participants continue to demonstrate a culture of blame, but they acknowledge that interactions among them were not as effective as they should have been. They offer more effective scenarios. We learn that the press is aware of the adverse event that Mrs. Romanov has experienced.

Themes

- Interdisciplinary communication
- Teamwork approaches
- Fear of regulatory agencies
- Conflict resolution while caring for the patient

Learning objectives

- Be able to list patient care situations in which a conflict resolution process could help.
- Describe some methods of dealing with regulatory agencies.
- Describe some ways (y)our institution provides assistance to the "second victim(s)."

Suggested discussion questions

- How do regulatory agencies in (y)our area respond to a report of an event such as the one depicted in this video?
- What is the role of the risk manager when an adverse event occurs? Does the role differ if the case has a high profile? Does the role of the risk manager differ from the role of legal counsel?
- How does (y)our institution respond to the clinicians involved in such an event? Is there a policy in (y)our (our) institution for conflict resolution when one provider disagrees with another?

- How do the clinicians resolve a conflict in care when they disagree as to the next steps in the process?

Additional resources

- Expert Interview Segment #7: Moving Beyond a Culture of Blame – Leadership's Role
- Focus on Patient Safety. http://www.npsf.org/download/FocusSpring2001.pdf.
- Helmreich, Robert, 2000. On error management: lessons from aviation, *BMJ* 320:781-785.
- Singer A., Wu A., Fazel S., McMillan J. 2001. An ethical dilemma: medical errors and medical culture - An error of omission; Commentary: Learning to love mistakes; Commentary: Doctors are obliged to be honest with their patients, Commentary: A climate of secrecy undermines public trust, BMJ 322: 1236-1240
- Lesson from Denver: look beyond blaming individuals for errors. ISMP Safety Alert *11 Feb. 1998*.

Scene E: Jack Heath Speaks

Description of the action

Jack Heath, newly elected chair of the board of director's Patient Care Committee, talks about his experience with the airline industry and responds to objections from meeting participants that health care is not the same as other industries. He acknowledges that the individuals in the room will need to develop ways to apply airline safety to health care, and discusses the need for mutual respect before lasting improvements can be made.

Themes

- Analogy to airline and other high-risk industry safety efforts.
- Need for mutual respect among all levels and all types of health care personnel.
- Need for focus on risks of small problems, so that they are addressed before they combine and cascade into serious systems failures.

Learning objectives

- Describe some similarities between the airline industry and health care.
- Discuss issues that might be included in a business case for patient safety.

- Discuss ways to promote mutual respect and trust between health care providers, and between health care providers and administration.

Suggested discussion questions

- Do you think that the analogy to aviation or other high-risk industries is appropriate? Is it helpful to you in understanding how health care could become more safety-centered or systems-based?
- Do you (we) have a system in (y)our institution to identify errors or small failures that do not result in patient harm?
- Do you believe that there is or should be a business case for patient safety?

Additional resources

- Expert Interview Segment #3: Learning From Other Industries
- Bogner S. (editor) Human Error in Medicine. (unpublished).
- Helmreich R. and Merritt A. Culture at Work in Aviation and Medicine: National, Organizational and Professional Influences.
- Reason J. 1990. *Human Error*. Cambridge University Press
- Reason J. Managing the Risks of Organizational Accidents. Cambridge University Press

"Terry, I need to see you out here."

Section 2: Scenes F-H

Expert Interview Segments following Section 2

4: Being Patient-Centered

5: Dealing With the Media

6: Working in the Safety Zone

7: Moving Beyond a Culture of Blame

(see Program Chart on page 28 for more details)

Scene F: The Reporter

Description of the action

The Romanovs are reintroduced. Ariana is in a coma with a poor prognosis as a result of the adverse event depicted in First, Do No Harm. Her husband, Tibor, has not received any information from the clinicians treating his wife or from hospital administration. A reporter who is working on a story dealing with medical error has learned about the case and wants to interview Tibor for the story.

Themes

- Communicating and providing support for the patient or family after an adverse event.
- Managing the media and potential for damage control.

Suggested discussion questions

- How does your institution support families in cases such as this?
- How do you manage the facts of a story such as this when dealing with the media?

Learning objectives

- Discuss the importance of communicating in a timely manner with patient/families after an adverse event.
- Describe how (y)our institution handles media inquiries.

Additional resources

- Interactive Break #2/Section 2B: Dealing With the Media
- Crane M. 1997. When a medical mistake becomes a media event. *Med Econ* 74: 158-162, 165-166, 168, 170-172.

- Millenson, ML. 2002. Pushing the profession: how the news media turned patient safety into a priority. Qual Safety Health Care 11; 57-63. Available at http://qhc.bmjjournals.com/cgi/content/full/11/1/57. 12 Sept. 2002.

Scene G: Put the Patient First

Description of the action

Terry McGiver, CEO, and Daria Pannessi, Director of Quality Management, describe the hospital's patient safety efforts. Board member Jack Heath replies that patient safety is not a project or an initiative; it should be "the program." Ariana Romanov's obstetrician,Dr. Baxter, begins the process of reconstructing the events of the office visit.

Themes

- External pressures from accreditation and purchasers.
- Placing the patient at the center of the safety net.
- Role of the clinician in understanding the barriers faced by support staff.

Learning objectives

- Describe how the JCAHO standards affect your patient safety efforts.
- Discuss the impact of the Leapfrog standards on your strategic plans.
- Discuss how patient safety is incorporated into (y)our institution's strategic plan.

Suggested discussion questions

- How do you decide which "best practices" to implement?
- How do you develop a patient-centered model?
- What do you need to provide to patients?
- How do you handle cultural and medical literacy issues?
- Can technology solve some of the problems that you face at your institution?
- For physicians and office managers: What are your policies regarding scheduling of patients? Is staff trained to handle situations such as the one depicted in this case?

Additional resources

- Expert Interview Segment #4: Being Patient-Centered
- Calloway, S. 2001. Preventing communication breakdowns, RN January.

- 2001. "Crossing the Quality Chasm: A New Health System for the 21st Century" Committee on Quality of Health Care in America. Institute of Medicine.

Scene H: The Handoff

Description of the action

Director of Risk Management Connie Goldman reviews the events of the case with the clinicians involved. The concept of the "safety zone", the area where providers exceed the barriers of safety provided by the system, is introduced. The meeting participants explore how the situation could have been handled differently through problem solving exercises.

Themes

- The application of the "safety zone" in health care.
- The role of each employee in patient safety.
- The role of "briefings" to improve communication.
- The impact of the nursing shortage on health care.

Learning objectives

- Discuss the concept of the "safety zone" and its role in health care.
- Describe the role of briefings.
- Describe how (y)our organization has made safety everyone's responsibility.

Suggested discussion questions

- What does it mean when we say that safety is everyone's responsibility?
- How do you help staff understand what that means and what each should and can contribute to patient safety?
- What is the method for staff to share their concerns about safety in (y)our institution?

Additional resources

- Expert Interview Segment #6: Working in the Safety Zone
- Blegen, M. & Vaughn, T. 1998. A multisite study of nurse staffing and patient occurrences. *Nursing Economic* 16, 196-203.
- Blegen, M.A., Goode, C.J., & Reed, L. 1998. Nurse staffing and patient outcomes. Nursing Research 47(1):43-50.

"How many accidents do we need?"

Section 3: Scenes I-J

Expert Interview Segments following Section 3

8: Tensions between Financial Concerns and "Putting the Patient First"

9: Crew Resource Management/Appropriate Assertiveness

(see Program Chart on page 28 for more details)

Scene I: Hallway Meeting

Description of the action

This section introduces Dr. Janowitz, Chief of Oncology and board member. In a hallway discussion, she suggests that the event is an isolated one and a problem specific to the obstetrics department.

Themes

- Conflicting interests: Are they in fact conflicting?
- Silo mentality. No working across departments.
- Using the legal department to communicate with the patient/family.
- Dealing with risk by using the legal department to communicate with patients/families.

Learning objectives

- Describe how to overcome the silo mentality.
- Discuss how (y)our institution would or should deal with the Romanovs.
- Describe how to integrate safety lessons across departments in (y)our institution.

Suggested discussion questions

- How would you handle this situation in (y)our institution?

- Do Dr. Janowitz's comments reveal anything about the culture in this institution?
- How are lessons learned and improvement initiatives shared across departments in (y)our institution?

Additional resources

- Expert Interview Segment #8: Tension between Financial Concerns and "Putting the Patient First"

Scene J: Resident and Nurse

Description of the action

Dr. Feldman recounts his encounter with Nurse Jones and realizes how he could have managed it differently.

Themes

- Residents learn behavior from role models/senior clinicians.
- The impact of excessive work hours on staff.
- The impact of fatigue on decision making skills and performance.
- Poor communication and how patient safety is affected.
- Crew Resource Management

Learning objectives

- Describe how the principles of Crew Resource Management can be applied to health care.
- List several ways in which (y)our institution is addressing excessive work hours.
- Discuss the impact of fatigue on performance.

Suggested discussion questions

- Do you think that the staff in this video is aware of the many human factors violations that have been committed? (e.g., fatigued staff, poor communications, task overload)

- Are the interactions in these scenes likely to be occurring in (y)our institution?
- Are there examples from other industries that we can apply to health care?
- How have you handled situations such as the ones depicted in this scene?

Additional resources

- Expert Interview Segment #3: Crew Resource Management/ Appropriate Assertiveness
- Expert Interview Segment #10: The Impact of Fatigue
- Helmreich, Robert., 2000. On error management: lessons from aviation. *BMJ* 320:781-785.
- Martin M. 2001. Asleep at the Wheel (shift workers and driver fatigue.) Occupational Hazards, July.
- Sexton, B. 2000. Error, stress, and teamwork in medicine and aviation: cross sectional surveys. BMJ 320:745-749.

"We're going to go and talk to Mr. Romanov. Jack, thanks for coming."

Section 4: Scenes K-M

Expert Commentary Interview Segments

10: The Impact of Fatigue

11: Briefings/Handoffs/Communication

12: Building Teamwork Into the Culture

(see Program Chart on page 28 for more details)

Scene K: The C-Section

Description of the action

The interactions in the OR during the emergency C-section are reviewed. Jack Heath is surprised to learn that the health care providers do not have team briefings to review what is known and to agree on a plan of action before "diving into" an emergency.

Themes

- The role of briefings to improve communication and decision making.
- The responsibility of each member of the health care team to communicate efficiently and effectively.
- Using appropriate assertiveness to improve communication.

Learning objectives

- Describe how "briefings" can improve the delivery of care.
- Discuss how this practice can be applied at (y)our institution.

Suggested discussion questions

- Do you have briefings in your institution?
- What is the value of having briefings?

Additional resources

- Expert Interview Segment#10: The Impact of Fatigue
- Expert Interview Segment#11: Briefings/Handoffs/Communication
- Helmreich, Robert, 2000. On error management: lessons from aviation, *BMJ* 320:781-785.
- Sexton, B. 2000. Error, stress, and teamwork in medicine and aviation: cross sectional surveys. BMJ 320:745-749.

Scene L: Improved Interactions

Description of the action

Dialogue has been changed to demonstrate how team interactions and communications can be improved in the operating room during preparation for the emergency C-section.

Themes

- The importance of teamwork and communication during an emergency.
- The role of team briefings when developing an action plan.

Learning objectives

- Describe how the principles of Crew Resource Management improve communication in health care.
- Discuss different methods clinicians can use to share information.

Additional resources

- Expert Interview Segment #4/Section 4B: Briefings/Handoffs/Communication
- Expert Interview Segment #4/Section 4C: Building Teamwork Into the Culture
- Helmreich, Robert. 2000. On error management: lessons from aviation, *BMJ* 320:781-785.
- Sexton, B. 2000. Error, stress, and teamwork in medicine and aviation: cross sectional surveys. BMJ 320:745-749.

Scene M: McGiver Decides

Description of the action:

Meeting participants realize one key person has not yet been included in their discussion. Terry McGiver decides that it is time to meet with Tibor Romanov. He asks Dr. Baxter and Connie Goldman to accompany him.

Themes

- The importance of keeping the patient/family informed about events that impact their care.
- How leaders can take responsibility.

Learning objectives

- Discuss the challenges and opportunities associated with being patient-centered.
- Discuss the issues and challenges in being "transparent," e.g., open to scrutiny by patients, the press, and other external audiences.

Suggested discussion questions

- What do you think of McGiver's decision to talk with Mr. Romanov? In (y)our organization, who is involved in the decisions about when to talk with a patient and what to say? Who makes the decisions?
- Who should disclose medical errors and the adverse events they may cause to patients? Should the CEO be part of the disclosure process? What role should (s)he play?

Additional resources

- Expert Interview Segment #4: Being Patient-Centered
- 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*. Committee on Quality of Health Care in America. Institute of Medicine

Section 5: Scenes N-O

"Betty, its Rachel from the hospital. I know you are there. Please pick up. I want to help."

Interview Segments

13: The Value of Walking Rounds

14: Transparency

15: Disclosure

(see chart on page 28 for more details)

Scene N: Disclosure

Description

As McGiver leads several individuals to Ariana's room, attorney Walcott advises against disclosure. He and Goldman argue. McGiver observes several systems weaknesses as he walks through his hospital, including factors that contributed to Ariana's bad treatment outcome. The staff is surprised to see Mr. McGiver walking through the institution. McGiver's group passes investigative reporter Wozniak as they walk.

Themes

- Using walkrounds to begin culture change within an institution.
- The value of an apology to maintain trust between clinicians and patient/family.
- Challenges faced by risk managers, legal counsel, and executive decision makers when disclosing an unanticipated outcome.

Learning objectives

- Describe how CEO walkrounds can be used to change the culture of an institution.
- Describe (y)our procedure for disclosing an unanticipated outcome.

Suggested discussion questions

- What is (y)our institution's procedure to disclose an unanticipated outcome? What are the issues encountered when making the decision?

- From the point of view of clinicians involved in an adverse outcome, what are the reasons for or against disclosure? What role do clinicians have in deciding whether or not to disclose?
- In (y)our organization, do executives walk through the hospital wards to talk with staff?
- Does the staff in (y)our organization think that administrators are aware of the patient care and safety issues they face daily? Does the staff feel that they can make recommendations that will be considered by the administrators?

Additional resources

- Expert Interview Segment #13: The Value of Walking Rounds
- Expert Interview Segment #14: Transparency
- Expert Interview Segment #15: Disclosure
- Frankel A., *Senior Executive "Walkrounds."* Institute for Healthcare Improvement, Boston:, http://www.ihi.org/conferences/natforum/handouts/M12_9.pdf.
- Kraman SS, Hamm G. 1999. Risk management: extreme honesty may be the best policy. *Ann Intern Med.*;131:963-967.
- Phillips, D. 1992. Lincoln on leadership. Warner Books.

Scene O: Talking to Tibor

Description:

Terry McGiver, Dr. Baxter, and Connie Goldman enter Ariana Romanov's room and begin a conversation with Tibor Romanov. Nurse Jones, alone at home, receives a phone call from the hospital. It's Rachel Klein, chief of nursing, offering to help.

Themes:

- Communicating with patients/families when there is an adverse event.
- Communication among clinicians involved in an adverse event.

Learning objectives

- Describe the disclosure practice at (y)our institution.
- Discuss the different points of view around the impact of disclosure.

- Describe the ways in which (y)our organization supports health care workers involved in systems failures that harm patients.

Suggested discussion questions

- Are clinicians in (y)our institution prepared to disclose unanticipated outcomes?
- If you were the person designated to talk with Mr. Romanov, what would you say?
- Would legal counsel in (y)our organization be involved in discussions with a patient or family after a serious adverse event? Should (s)he be? Why or why not?
- If you were Betty Jones, what could the organization or your colleagues do to help you?

Additional Resources

- Expert Interview Segment #15: Disclosure
- ECRI. 2002. Disclosure of unanticipated outcomes. Health Risk Control *Suppl A:1-13*.
- *Is Honesty the Best Policy?* Resource February 2000,*http://www.rmf.harvard.edu/publications/resource/feb2000news/article2/index.html*.
- Roover JE, Effron DD. 2002. Mediation breaks the wall of silence. Focus Patient Safety. 5:6-7.http://www.npsf.org/download/FocusSpring2002.pdf, 19 Jul. 2002.
- Wu, A. 2000. Medical error: The second victim, BMJ 320:726-727.
- Goldberg, RM, Kuhn, G., et al. 2002. Coping with medical mistakes and errors in judgment. Ann Emerg Med 39:287-292.

Program Chart

Drama

The drama has been segmented into scenes A-O. Each scene may be accessed individually through the main menu on the DVD.

Interview Segments

The fifteen interview segments can be accessed individually from the DVD's main menu. After each of the five sections of the drama, an onscreen prompt will also appear. When you press enter for "further discussion," interview segments related to each section will appear.

	DRAMA	INTERVIEW SEGMENTS
SECTION 1	Scene A: Flashback Scene B: McGiver Arrives Scene C: Meeting Begins Scene D: Conflict Arises	1: The Value of Sentinel Events 2: Leadership's Role in Creating a Culture of Safety 3: Learning From Other Industries
SECTION 2	Scene F: The Reporter Scene G: Put the Patient First Scene H: The Handoff	4: Being Patient-Centered 5: Dealing With the Media 6: Working in the Safety Zone
SECTION 3	Scene I: Hallway Meeting Scene J: Resident and Nurse	8: Tensions between Financial Concerns and "Putting the Patient First" 9: Crew Resource Management/Appropriate Assertiveness
SECTION 4	Scene K: The C-Section Scene L: Improved Interactions	10: The Impact of Fatigue 11: Briefings/Handoffs/Communication 12: Building Teamwork Into the Culture
SECTION 5	Scene N: Disclosure Scene O: Talking to Tibor	13: The Value of Walking Rounds 14: Transparency