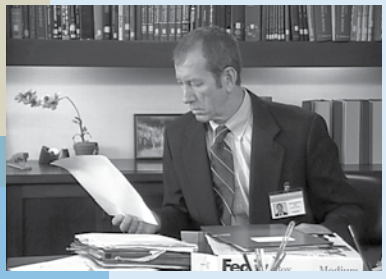
p4ps®
Partnership for Patient Safety®



First, Do No Harm Film® Series

THE BEST PATIENT-SAFETY EDUCATIONAL VIDEOS AND WORKSHOPS

ABOUT THE SERIES

The *First, Do No Harm* interactive video series and workshops are a highly acclaimed set of case-based, teaching tools developed to assist healthcare delivery organizations and schools implement a systems approach to reducing preventable patient harm.

MEET P4PS

The series is produced by Partnership for Patient Safety (p4ps), a patient-centered initiative to advance the reliability of healthcare systems worldwide. Since its establishment in 1999, p4ps has been an innovator in the development of patient safety educational tools, including national and international conferences, executive workshops, consumer outreach activities, patient safety curricula and a leading text, *The Patient Safety Handbook* (Jones & Bartlett, 2004). p4ps is also an international leader in paving new pathways for constructive consumer engagement in patient safety.

First, Do No Harm debuted in June 2000 at a major patient safety conference, originating in response to the healthcare "culture of blame" concerns raised by the Institute of Medicine in its landmark call-to-action report, *To Err is Human: Building a Safer Health System* (National Academy Press, 2000). Demand for the films quickly grew in the emergent patient safety community. Today the series is used in nearly 40 countries.

"TO ERR IS UNAVOIDABLE – TO HARM IS UNACCEPTABLE"

The *First, Do No Harm* films and workshops tell a real-life story drawn from the closed malpractice claims files of the Risk Management Foundation (RMF) of the Harvard Medical Institutions. While the story depicts an expectant mother's journey through a busy healthcare system, the spectrum of safety and ethics issues developed by the case study transcends obstetrics care: i.e. is error tolerable? If to err is human, can we expect to prevent harm caused by error? What are the organizational responsibilities for safety, patient-centered care versus those of individual doctors or nurses? Can we learn useful lessons from our past, from other healthcare organizations, from other industries? How do we treat the human needs of victims and their families as well as those of "second" victims, i.e. caregivers traumatized by the harm they cause? Should we apologize when we disclose medical errors? How do we advance?
The series consists of three sequential case studies, each approximately 20 minutes in length. They work well in a one-hour educational format, and are rich enough in content to also support more in depth programming. Films are dramatized to produce high educational impact while maintaining high fidelity to actual events faced in real time by real doctors, nurses, patients and their families – the hallmark of the *First, Do No Harm* brand. Each case study is supported by additional learning tools. These include commentary from leading experts from healthcare and other industries, as well as facilitators' guides developed by risk management educators that detail scene-by-scene learning objectives and discussion points.

WORKING TO MAKE HEALTHCARE SAFER

First, Do No Harm has enjoyed tremendous receptivity with hospitals and healthcare educational organizations. They use the series over and over again, among a variety of disciplines within their workforce communities, making these films part of their on-going training and new-employee orientation, raising awareness, stimulating discussion about thorny problems, exploring disclosure and apology options, and reinvigorating the focus on patient safety that is the heart of our work in healthcare.

Our customers tell us that *First, Do No Harm* is an invaluable aid in helping their organizations assess current systems, make actionable improvements to reduce preventable harm, and encourage care that is authentically patient-centered. We invite you to try our products and hope you too will find them to be best in class.

Martin J. Hatlie, Esq.,
President, p4ps

First, Do No Harm workshops are interactive educational events built on the *First, Do No Harm* video series. They are designed to assist p4ps customers implement systems-based theory and overcome cultural barriers that preclude patient-centered care.

APPROACH

The workshops use a practice-based learning approach grounded in adult learning theory. This takes into account the experiences adults bring to the learning environment and their need to interactively learn activities that have clear application to their work. All *First, Do No Harm* workshops are customized to the roles and concerns of diverse participants, including governance, executive leadership, middle management, frontline healthcare workforce, or a combination of these participants. This approach enables individual and team learning in key areas of patient safety and also fosters an on-going working culture of patient safety.

WORKSHOP SERIES

Workshop 1: What happened here? And what do we do now?
Content: This introductory workshop program builds on the *First, Do No Harm* films, which follow the course of a healthy, pregnant patient who gradually falls victim to a busy healthcare system. It is designed to present the foundation of the "new look" at systems-based safety management and the prevention of sentinel events. The workshop is an excellent introductory tool for governing boards, senior management and frontline health workers.
Learning Goals: (1) Understanding the ways in which complex systems fail, with special attention to handoffs, teamwork problems, distraction, communication breakdown and authority gradient barriers; (2) exploring the dynamics of the patient safety movement; the basic tenets and models of safety science, JCAHO patient safety goals; and environmental pressures (law, press, consumers, purchasers) advancing patient safety now; and (3) discovering the applicability of this body of knowledge to participants' roles and practice.

Workshop 2: Disclosure as an opportunity: Let's do "the right thing" strategically, expertly and compassionately.
Content: Despite growing evidence that effective disclosure and apology reduces liability and aides healing of both patient and provider, survey after survey confirms that healthcare workers are not comfortable disclosing medical error to patients and families who experience preventable harm. This dynamic workshop examines alternative methods for disclosing and/or apologizing after a medical failure. Participants engage in role playing and coaching as they practice actual conversations about a variety of systems failures with a variety of patient personalities. Participants also explore strategies for creating a trustworthy culture of safety that includes trauma support assistance for healthcare workers involved.
Learning Goals: (1) Improving personal performance and effectiveness in disclosure and apology; (2) improving organizational performance via a roadmap for establishing a disclosure "consult" for ongoing professional support and continuous skill-building.

Workshop 3: Patient engagement in safety work: An aspirational approach to meeting new JCAHO requirements
Content: JCAHO's new patient engagement requirement (National Patient Safety Goal 13, effective January 2007) mandates active efforts to engage patients in reporting safety concerns or preventing harm through appropriate participation in their own care. This workshop takes a positive approach, building on a growing foundation of research that shows effective patient engagement produces better outcomes. Workshop facilitators also include a patient advocate who will explore the ways in which patients and families (1) see things that busy healthcare providers often do not, (2) can contribute to error prevention and recovery activities, and (3) can be dedicated partners for healthcare provider organizations who wish to reduce errors and demonstrate patient-centered values.
Learning Goals: (1) Identifying new pathways for integrating patient/family participation in safety work, resolving consumer safety complaints, and developing effective patient education materials; (2) implementing a proactive organizational strategy for satisfying JCAHO's new NPSG 13.

SCHEDULING AND FEES

Each workshop meets for one day and is designed to accommodate groups of up to 50 participants. Training is conducted by two expert facilitators and is priced at $6,000 per day plus expenses. All workshops can be tailored to support on-going safety priorities that an organization may already have. Arrangements may also be made in advance for retreats, conferences of varied duration, or groups of larger audiences in order to fit your needs. Please contact us directly at p4ps to schedule workshops or for more information.

First, Do No Harm® Part 1

A dramatized case study and interviews with national patient safety leaders on crucial topics:

A Case Study of Systems Failure

DVD, VHS
Price: $795

by p4ps in collaboration with the Risk Management Foundation of the Harvard Medical Institutions

Average Customer Reviews [1]: ★ ★ ★ ★ ★

Based on actual events drawn from medical liability claims files, *First, Do No Harm Part 1: A Case Study of Systems Failure* (FDNH1) tells the story of Ariana Romanov, a healthy pregnant woman, and the healthcare workers who treat her and her newborn child. Dramatically illustrating how small medical failures build on each other, this powerful program raises awareness about how complex systems fail in even the best hospitals and fosters understanding about a systems approach to ensuring patient safety.

LEARN IN JUST 1 HOUR HOW TO:

- Understand healthcare as a complex system, inherently risky, prone to failure
- Understand patient safety s a non-punitive systems concern
- Raise awareness of how human and organizational factors compromise patient safety, including: poor communication, staff fatigue, nursing shortage, poor hand-off, poor teamwork, poorly-designed process and facilities
- Help staff understand the impact of their individual contributions in the patient's journey through the system
- Raise awareness of the importance of speaking up regarding errors and asking for help in real time
- Assist staff in understanding patient safety issues, including: clinical staff, executive management, middle management, governance, human resources

TABLE OF CONTENTS

Scene index:

Discussion segments:

TRAINING PROGRAM INCLUDES

- DVD and VHS format featuring:
  18-minute drama
  50 minutes of optional Discussion
- Segments, using national patient safety leader's commentary
- Facilitator's Guide

[1]Based on 2006 p4ps customer survey

First, Do No Harm® Part 2

A dramatized case study and interviews with national patient safety leaders on crucial topics:

Taking the Lead

DVD, VHS
Price: $795

by p4ps in collaboration with the Risk Management Foundation of the Harvard Medical Institutions

Average Customer Reviews [1]: ★ ★ ★ ★ ★

First, Do No Harm Part 2: Taking the Lead (FDNH2) is a sequel to FDNH1 that portrays a hospital community's typical response to a sentinel event and the complications it can raise. It also examines the psychological impact on healthcare workers involved in the adverse event. It is designed to raise awareness and stimulate dialogue about internal organizational barriers to taking a systems approach that can engender positive change.

LEARN IN JUST 1 HOUR HOW TO:

- Understand the importance of making patient safety a top priority of the organization
- Recognize organizational barriers to taking a systems-based approach to patient safety: organizational inertia, culture of perfectionism and hierarchy, fear of litigation and publicity, fear of personal and professional consequences
- Raise awareness of organizational barriers to treating patients and families respectfully: lack of training in crisis response, lack of coordination in crisis response, lack of resources (i.e. staff, time)
- Recognize the need for hospital staff to be able to speak openly during internal post-incident discussion
- Recognize the importance of investigating root causes of failure with a non-punitive approach
- Understand the trauma of failure to healthcare workers, aka the "second victims"
- Assist staff in understanding organizational barriers, including: executive and middle management and governance

TABLE OF CONTENTS

Scene index:

Discussion segments:

TRAINING PROGRAM INCLUDES

- DVD and VHS format featuring:
  19-minute drama
  35 minutes of optional discussion
- Segments, using national patient safety leader's commentary
- Facilitator's Guide

[1] Based on 2006 p4ps customer survey

First, Do No Harm® Part 3

A dramatized case study and interviews with national patient safety leaders on crucial topics:

Healing Lives, Changing Cultures

DVD, VHS
Price: $795

by p4ps in collaboration with the Risk Management Foundation of the Harvard Medical Institutions

Average Customer Reviews [1]: ★ ★ ★ ★ ★

First, Do No Harm Part 3: Healing Lives, Changing Cultures (FDNH3) brings resolution to the issues raised in FDNH1 and FDNH2. The film explores how an organization can learn from systems failure, formulate a comprehensive solution and create a just and supportive culture for both patients and healthcare workers. It is designed to assist organizations to implement positive change and successfully deal with the media upon the occurrence of adverse events.

LEARN IN JUST 1 HOUR HOW TO:

- Discover how other healthcare organizations have successfully responded to systems failure
- Explore how lessons have been learned from past systems failures
- Find out how other healthcare organizations have created a just and supportive culture
- Find out how other healthcare organizations have implemented successful solutions to make patient safety a top priority
- View how other healthcare organizations have formed a coordinated, patient-centered response to a sentinel event
- Discover how other healthcare organizations have successfully dealt with the media

TABLE OF CONTENTS

Scene index:

Discussion segments:

TRAINING PROGRAM INCLUDES

- DVD and VHS format featuring:
  26-minute drama
  61 minutes of optional discussion
- Segments, using national patient safety leader's commentary
- Facilitator's Guide

[1]Based on 2006 p4ps customer survey

SELECTED CUSTOMER LIST

HOSPITALS & HEALTH SYSTEMS

Albert Einstein Medical Center
Arlington Memorial Hospital
Austin Regional Clinic
Baylor Health Care System
Battlecreek Health System
Beth Israel Deaconess Memorial Hospital
Brigham and Women's Hospital
California Pacific Medical Center
Carolinas Medical Center
Columbus Regional Hospital
Dana Farber Cancer Institute
Dartmouth-Hitchcock Medical Center
Doctors Hospital Augusta
Duke University Hospital
Fairfield Medical Center
Good Samaritan Hospital
Harbor UCLA Hospital
Hawaii Health Systems
HCA
Henry Ford Medical Center
Indiana Regional Medical Center
Intermountain Health Care
Iowa Medical Center
JFK Medical Center
Johns Hopkins Outpatient Center
Kaiser Permanente
Loyola University Medical Center
Lynchburg General Hospital
Madigan Army Medical Center
Maine Coast Memorial Hospital
Maine Health
Maui Memorial Medical Center
Mayo Clinic
Massachusetts General Hospital
Memorial Sloan-Kettering
Missouri Baptist Medical Center
Montgomery County Memorial
National Naval Medical Center
Nebraska Methodist Hospital
North Colorado Medical Center
Northeastern Vermont Regional
Northwestern Memorial Hospital
Norwegian American Hospital
Phelps Memorial Hospital Center
Phoenix Area Indian Health Service
Premier, inc.
Providence Newberg Hospital
Providence Alaska Medical Center
Rush Presbitarian St. Luke's Hospital
Rush Hospital
St. John's Mercy Hospital
St. Joseph's Hospital
St. Jude Medical Center
St. Luke's Hospital
Scripps Memorial Hospital
Seattle Children's Hospital
Stanford Hospital & Clinics
Stony Brook University Hospital
Swedish American Hospital
Texas Children's Hospital
University of Michigan Hospital
University of Pennsylvania Hospital
U.S. Navy Hospital
VA San Diego Health System
VA Medical Center
Vanderbilt University Hospital
Virginia Baptist Hospital
VHA Inc.
Wyoming Valley Health Care
Yale-New Haven Health System

INSURANCE

Farmers Insurance
Healthcare Insurance Reciprocal of Canada
Medical Liability Mutual Insurance Co.
MICA
Midwest Medical Insurance Company
Northwest Physicians Mutual

INTERNATIONAL

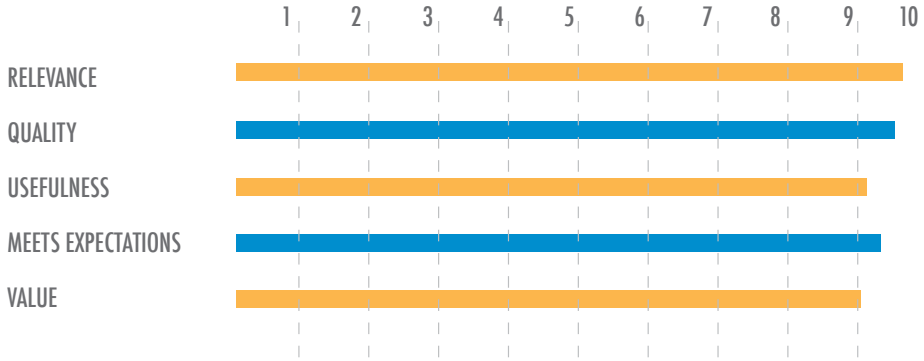
Alabang Medical Clinic, Philippines
Bolton Hospitals NHS Trust, U.K.
Clalit Health Systems, Israel
HCUGE Hospital, Switzerland
Mt. Sinai Hospital, Canada
National Taiwan University Hospital, Taiwan
Singapore General Hospital, Singapore
The Norwegian Medical Association, Norway
Viborg County Hospital, Denmark
VU University Medical Center, The Netherlands

SCHOOLS

Boston University School of Medicine
Dartmouth Medical School
Georgetown University School of Medicine
Harvard Medical International
Johns Hopkins University Nursing School
Samford University Nursing School
UCCS College of Nursing
University of Minnesota Medical School
University of North Carolina School of Nursing
University of Tennessee School of Nursing
Washington U. School of Medicine
Wake Forest School of Medicine

WHY OUR CUSTOMERS CHOOSE THE FDNH FILM SERIES

Today there are many organizations who are using FDNH films every day and their enthusiasm for our products continues to be the best form of compliment. We asked them why they love the films so much. While they said that the FDNH films are in a league of their own, this is how they rated their satisfaction with our product:



Source: 2006 p4ps product survey

ORDERING INFORMATION

CONTACT

❑ FOR FDNH VIDEO PRODUCTS

To order or for more information, go to our web site at **www.p4ps.net**

❑ FOR FDNH WORKSHOPS

Call **1-312-464-0600** for arrangements

PRICING

The First, Do No Harm products are being offered at the unit price of $795

Part 1 Video at $795
Part 2 Video at $795
Part 3 Video at $795

Shipping and handling will automatically be included

Add 9% sales tax if shipping to an Illinois address

Workshops are priced at $6,000 per day

DISCOUNTS

- ❑ 10% discount is available for non-profit and government organizations
- ❑ 5% discount is applied when purchasing the entire set
- ❑ Volume discounts are available for purchases of 5 or more units. For more information on bulk purchases, go to **http://www.p4ps.net/Pricing_and_Discounts.html**

The Joint Commission first worked with p4ps founders ten years ago in the development of what became the seminal conference on patient safety in the United States. This first Annenberg Conference on patient safety – *Examining Errors in Healthcare* – was held in October 1996. People who attended the event well remember our shared sense of a new reality -- a whole new way of seeing the depth and breadth of risk and what needed to be done to address this risk.

"First, do no harm," a principle derived from the Hippocratic Oath, enjoins doctors and other clinicians to pay the utmost attention to the profound consequences of their actions as healers. Nothing is more fundamental to healthcare than the patients who trust caregivers and institutions with their lives. And yet to truly appreciate the challenge posed by this principle, we in health care must come to terms with just how prone to failure the delivery of care has become and how unprepared we are to deal with it. How can we effectively fulfill our oath when "to err is human" and even the best doctors, nurses and pharmacists inevitably make mistakes? Is error tolerable? Do we expect too much? What should we expect?

Safety science infuses a new perspective on potential solutions to these problems. The core concept is that complex organizations fail as systems. This understanding shifts the emphasis away from whether the doctor, the nurse or the pharmacist are to blame for their errors to more comprehensive knowledge as to how a health care organization operates, delivers care and succeeds or fails as a system whose functioning relies on well intended, but fallible human beings. We are now called upon to apply this new understanding to achieve much higher levels of safety and reliability than we do now.

Our best chance for improvement is to work together as health care professionals, health care executives, patient safety officers, risk managers, safety experts and "policy makers," among others, to develop strategies that will result in a real systems change. Together we can learn how patient care processes fail and what we can do to rescue patients when things begin to go wrong. Examination of attitudes that prompt the hiding of mistakes instead of learning from them is also an imperative. Health care organization cultures must ultimately be trusted to be just and be supportive of those who work within them. When that happens honesty in talking about and learning from error will become the norm. No job is more important, but our journey – ten years after Annenberg – has still only just begun.

Dennis S. O' Leary, MD
President
Joint Commission on Accreditation of Healthcare Organizations

The potential for medical accidents and near misses is a reality. In 1999, the Institute of Medicine issued a call to action to healthcare providers and policymakers, acknowledging medical error as a public health epidemic that kills 44,000 to 98,000 a year – a statistic unacceptable by any standard.

At Children's Hospitals and Clinics of Minnesota, we believe that if we injure one child, that is one too many. When an error occurs or an accident happens, it is a defining moment for our organization. How such an event is viewed shapes what our culture is, now and looking forward. Children's of Minnesota has chosen a path of open disclosure, analysis of accidents, learning, prevention and face-to-face accountability, where administrative leaders stand shoulder to shoulder with affected family members and professional care givers.

When I first saw the original *First, Do No Harm* at a p4ps conference in 2000, I knew we needed it. At the time, a crucial step for Children's of Minnesota was to help our community see medical accidents as breakdowns in the complex system of care, rather than isolated events of one doctor or one nurse. We also found great value in the attention paid to the devastating impact of error on professional caregivers, the "second victims", in addition to patients and families. I have seen nurses give up the careers they love in the aftermath of medical error, and that is a tragedy in itself. We believe that recovery occurs when we create a safe place to talk about what happened as a learning experience.

We use the *First, Do No harm* films frequently and have actually built the series into our new-employee orientation program and ongoing training. The films are wonderful tools for achieving, nourishing and sustaining a culture of safety: they prompt everyone from our board members to our practicing physicians and nurses to non-clinical support personnel to see themselves in real-life case studies. The characters model the human drama, the resolution and the compassion that our community at Children's embodies, promoting tactful discussion about error and positive and constructive recovery. The films are exceptionally valuable tools and continue to be immensely successful, never failing to help people remember that our core value at Children's Hospitals and Clinics of Minnesota is, quite simply, first, do no harm.

Julianne Morath, RN, MS
Chief Operating Officer
Children's Hospital and Clinics of Minnesota

"At OSF HealthCare, we have used *First, Do No Harm,* Parts 1 and 2, as the core of our safety training for over 700 leadership employees, including those with top leadership responsibilities. We found the films to be powerful tools for engaging our leaders and sparking important discussion and education in our safety journey."
- ***John Whittington**, MD, Patient Safety Officer/Medical Director of Knowledge Management, OSF Healthcare System*

"The *First, Do No Harm* Series is an extraordinary achievement that brings to life many of the key systematic and cultural problems responsible for patient mishaps… Having used the *First, Do No Harm* Series with over 1,000 health care leaders I have found no other video series that both demonstrates these issues while also resonating emotionally with the audience."
- ***Steven B. Meisel**, Pharm.D., Director of Medication Safety, Fairview Health Services*

"We use the entire series of *First, Do No Harm* videos with every new orientee to our hospital. The response to them is amazing. The message is well delivered and provides a long term impact for our staff."
- ***Joanne Nathem** RN, MS, Chief Nurse Executive, Montgomery County Medical Center*

"The *First, Do No Harm* series bridges the gap between patient safety rhetoric and real practice change. Richly layered with characters, settings, and events, the videos can be played many time for many different audiences. Each viewing reveals flaws in the systems that are disturbingly familiar, poignant, and eminently fixable."
- ***William M. Sage**, MD, JD, Vice Provost for Health Affairs, The University of Texas at Austin School of Law*

"Fulfilling our moral and ethical responsibilities for quality care and advancing patient safety requires that we honestly examine the realities of our practice. The *First, Do No Harm* series of films is an invaluable tool in confronting the realities, stimulating crucial conversations, and advancing quality safe care in a partnership among patients, family members, and staff."
- ***James B. Conway**, MS, Senior Vice President, Institute for Healthcare Improvement*

"The *First, Do No Harm* films are extremely engaging building blocks…They help professionals viscerally appreciate the way they can be set up to fail – and their patients to be harmed -- by poorly organized work systems. They also assist leaders to see the payoffs for investing in better teamwork, more thoughtful and compassionate disclosure practices, and increased transparency."
- ***Troyen A. Brennan**, MD, JD, MPH, Chief Medical Officer, Aetna*

"This excellently executed film shows us the courageous path - also the safest path - to managing medical events that have involved harm. If all medical leaders and clinicians had the insight this film has to offer, the medical system could dramatically improve."
- ***Linda Emanuel**, MD, PhD, Professor of Medicine, Feinberg School of Medicine*

"*First, Do No Harm* is a compelling teaching tool used in a variety of educational programs offered to MICA insured physicians and their staff, as well as to third year medical students. Attendees report that the film is impressive and meaningful"
- ***Judy Avery**, RN, BS, Education Coordinator, MICA Risk Management Services*

"*The First, Do No Harm* series has been and continues to be perhaps the most effective and important video-based learning tool in the patient safety arsenal: No healthcare professional who views it comes away unmoved. There is literally no one concerned with improving healthcare's patient safety performance who does not need this series. No one."
- ***John J. Nance**, JD, ABC News*

"[FDNH] … an excellent example of Reasons' model of systems failure."
- ***Harvard Business School**, "Why Complex Systems Fail," by Professor Steven J. Spear, Case 5-604-083, November 2004*

"A classic audiovisual presentation"
- ***Agency for Healthcare Research and Quality**, Patient Safety Network*

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Partnership for Patient Safety®

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