



## Leadership in Tragedy: Supporting Staff Especially Those Closest to the Patient and Family

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### Outline

- Leadership’s Role At the Time of Crisis
- Prioritized Response After a Tragic Event
- Never Losing Sight of Staff
- Burden of Tragedy on Staff
- Leadership Over Time
- Resources



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*“You just heard at this morning’s CEO leadership huddle that a 40-year-old father of five children died in the Surgical ICU last night, hours after receiving medication intended for another patient. Everyone is upset. Questions are flying around the hospital: What does the family know? Who did it? What happened? What can we say? Would the patient have died anyway (he was very sick)? Has anyone gone to the press?”*

**Think of the staff in particular.  
What would happen at your organization?**



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### From the field...

- "I was told stuff happens, you got to move on. I was sent back to the OR for the next case."
- "Everyone treated me different...like I was contagious"
- "We had no system to support our staff after the birth injury. They needed help and I just looked at the floor"
- "He asked me how I could have done something so stupid.. I loved that patient."
- "The Nursing Board went after us for 5 years to give us a scarlet letter"
- "I cared for her for 10 years. How do I tell her that I have permanently damaged her kidneys."
- "They wouldn't let any of the staff who cared for her for the last week sit in on the RCA."
- "I'm leaving medicine"
- "I'm scared to talk about it. If I open the door on this case, a flood gate of unspoken emotions over my career could erupt."




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### Whose Owns This?

1. Board of Trustees (Governing Body)
2. CEO
3. Executive Leadership
4. Middle Management
5. Front Line Staff

In short, leadership at every level owns it




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### 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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### Areas Requiring Focus

(In this order)

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




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“Many professionals respond to error with serious emotional distress, and these emotions can imprint a permanent emotional scar. Given the significant burden on physicians’ health, well-being and performance associated with medical errors, health care institutions and clinical leaders have to take accountability and provide staff with formal and informal systems of support”

Schwappach DLB, Boluarte TA. The emotional impact of medical error involvement on physicians: a call for leadership and organisational accountability. <http://www.smw.ch/docs/pdf200x/aop/smw-aop12417.pdf>

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### Staff

- Assure their personal safety and provide them support at a level they chose
- Invite them to participate in the RCA process
- Include them in the processes that bring resolution
- Assure there is learning, improvement, and healing

Never lose sight of the staff at the sharp end of the error




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## Never Lose Sight of Staff

- Don't jump to conclusions
  - "We'll figure this out together"
  - Be fair and just
  - Consider J. Reasons Decision Tree
- Appoint a staff member contact 24/7
- Provide support immediately and into future
  - EAP and other supports
  - Personal visits
- 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



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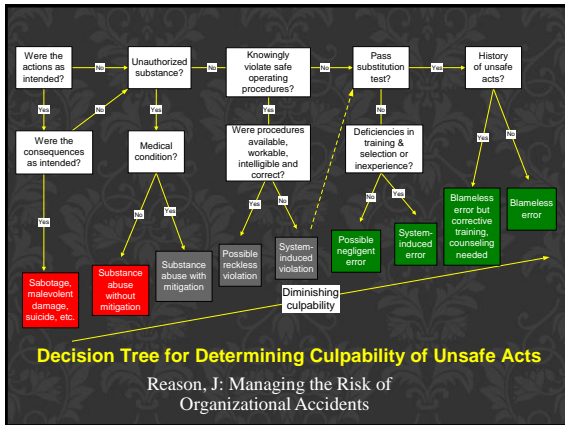
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A good resource: National Patient Safety Agency Incident Decision Tree

- <http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/incidentdecisiontree/?locale=en>

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## Internal Communications Critical

- All staff devastated when these events happen
- Need to understand what's going on as staff, consumers, and sources of information
- Good communications mitigates the "drop a dime" phenomenon
  - Action not visible around immediate incident
  - Frustration over historical issue resolution
  - Organization not "telling the truth"
- Communications should continue over time

Note: Routine communication of errors facilitates communication of serious incidents.



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## Moving Forward

"Our systems are too complex to expect merely extraordinary people to perform perfectly 100% of the time. We as leaders must put in place systems to support safe practice."

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## Ongoing Systems to Support Staff After Unanticipated Outcomes

- Establish formal and informal systems for peer support
- Set principles of a fair and just culture, approve them, communicate them, and hold people accountable to them
- Integrate these activities into a comprehensive system for management of serious clinical adverse events.



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## Organizations Seeks to Establish A Fair and Just Culture

One that values fair, objective and explicit decision rules for determining accountability and culpability subsequent to an adverse event.

<http://www.dana-farber.org/pat/patient-safety/patient-safety-resources/docs/principles-of-a-fair-and-just-culture.pdf>



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## Principles: An Example From DFCI

1. DFCI strives to create a learning environment and a workplace that support the core values of impact, excellence, respect/compassion and discovery in every aspect of work at the Institute
2. DFCI supports the efforts of every individual to deliver the best work possible. When errors are made and/or misunderstandings occur, the Institute strives to establish accountability in the context of the system in which they occurred.
3. DFCI commits to holding individuals accountable for their own performance in accordance with their job responsibilities and the DFCI core values. However, individuals should not carry the burden for system flaws over which they had no control.

<http://www.dana-farber.org/pat/patient-safety/patient-safety-resources/docs/principles-of-a-fair-and-just-culture.pdf>



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## Principles: An Example From DFCI

4. DFCI promotes open interdisciplinary discussion of untoward events (errors, mistakes, misunderstandings or system failures resulting in harm, potential harm or adverse outcome) by all who work, visit or are cared for at the Institute.
5. DFCI acts to improve all areas of the workplace by implementing changes based on our analysis of problems and potential or actual harm.
6. DFCI commits to a culture of inclusion and education.
7. DFCI will assess our success in promoting a learning environment by evaluating our willingness to communicate openly, and by the improvements we achieve.

<http://www.dana-farber.org/pat/patient-safety/patient-safety-resources/docs/principles-of-a-fair-and-just-culture.pdf>



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## RESPECT

*Everyone in the organization can say "yes" to three questions every day*

1. I am treated with dignity and respect by everyone I encounter every day. Everyone is accorded exactly the same high level of dignity and respect.
2. I am given the things I need; education, training, tools, encouragement, and protections from risk so that I can make a contribution to the work of the institution, THAT GIVES MEANING TO MY LIFE.
3. I am recognized for what I do.

Paul O'Neill




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## Clinician/Staff Support

- Multiple models, extensive resources
- Starts with respect, a hug, and listening
- Requires leadership by leadership



Care Elements	Things to Consider	Tools, References, and Examples
Internal Culture of Safety		

<http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html>




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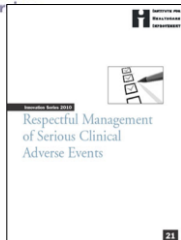
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***In the aftermath of an serious adverse event, the patient, family member, staff, and community all say they were treated with RESPECT.***



<http://tinyurl.com/IHIEffectiveCrisisMgmt>

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