M10. Leading in a crisis; the power of transparency

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Former CEO, Mid Staffordshire NHS Trust, UK

We have no conflicts of interest to declare
Agenda; morning

8.30am Introductions and welcome
8.45am Personal Leadership stories
  • 26 years as a CEO  Blair
  • The crisis we hoped would never happen  Kevin
  • Mid Staffordshire inheriting a crisis  Maggie

10.15am Break
10.45am Pre-work feedback  Kevin
11.00am Group-work  All
  Identify crises, form teams, prepare for role play
12.00md Working lunch

Agenda; afternoon

1.00pm Role play  
  Teams present crisis management plan to press conference
2.30pm Break
3.00pm Supporting second victims  Kevin
3.30pm The press and the media  Blair
3.45pm Personal action statements  All
  Feedback
4.00pm Close
Introductions

• Who you are
• What you do
• Where you work
• One sentence on why you are here

Personal leadership stories
The crisis that we hoped would never happen

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Consultant Geriatrician, Winchester

Kevin.stewart@rcplondon.ac.uk
• Geriatrician, Winchester, UK since 1995
• Medical Director (CMO) Royal Hampshire County Hospital, Winchester, UK, 2004-9
• Health Foundation Quality Improvement Fellow at Institute for Healthcare Improvement, Boston 2009/10
• MPH Harvard School of Public Health 2011
• Safety Thermometer programme, DH, London 2010/11
• Currently Director, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians, London

*Please respect the confidentiality of the patients, families and staff discussed in this presentation*

Winchester, UK, Christmas 2007......
Anne

Aged 39
Schoolteacher
3rd pregnancy

Anne

• Admitted in labour, Thurs. 20th Dec.
• Normal delivery 01.10am Friday.
• Home Friday am, apparently well.
• Readmitted Saturday am; non-specific abdominal pain
• Clinically stable; thought to have constipation
Anne

- Sudden deterioration 4pm with signs of septicaemia
- Transferred to ICU
- Died Sunday 23rd December from multi-organ failure secondary to Group A Streptococcus (GAS) septicaemia

Jenny

Aged 29
Schoolteacher
First pregnancy
Jenny

- Admitted in labour, Thursday 20th Dec.
- C/section 01.17am Friday
- Discharged home 6pm Sunday
- Cough and exacerbation of asthma overnight Sunday/Monday

Jenny

- Called GP Monday, Xmas Eve
  - Prescribed inhalers, antibiotics
- Collapse at home 1pm
- Died in ED at 4pm Monday 24th Dec
- (Initial suspicion of PE, but autopsy confirmed GAS pneumonia)
Context

- Maternity Unit has 2,500 deliveries annually
  - Above average ratings
  - Well-regarded locally
  - (Previous maternal death 1996)
- Recent increase in GAS infection in the local community
  (In the UK, from 2006 to 2008 there were 13 maternal deaths linked to GAS)

Context 2

- An organization in transition
  - New CEO, first post
  - New Chairman
  - Several Trustee and executive team vacancies, interims etc
- Holiday time
4pm, December 24th

• 2 maternal deaths in last 24 hours
  – One (clinically) GAS
  – The second not obviously related at this stage but......
• An inexperienced and incomplete leadership team
• Holiday time; most non-clinical staff had left for the holidays

Immediate concerns

• Could this really be as bad as it seems?
  – How could the cases be linked?
  – Are staff implicated?
  – Could there be ongoing risk?
  – What do we do now?
• Are there any existing mechanisms for dealing with this sort of thing?
Chronology

Dec 24th;
- Inform regulators, Board, Commissioners, Public Health, Coroner
- Identify family support

Dec. 26th;
- Autopsy
- Ad hoc “crisis team” convened twice daily

Chronology

Dec 26th;
- Public Health advise against closing
- GAS screening of staff, families etc
- Began working on plans for;
  - Legal
  - Press
  - Regulator(s), DH, local politicians
  - Family support
  - Staff
Dec 26th – Jan 4th

- Information for patients and families
  - Daily updates for families by a senior clinician
- Screening of staff, patients, family members of cases
- Others become symptomatic
- 5 staff screened positive
- Another patient developed GAS pharyngitis

Dec 26th – Jan 4th

- Twice daily crisis team meetings, providing updates for staff, Board, regulators, DH, Public Health etc
- No more cases
- Mothers kept coming
- Sub-typing of GAS strains found only 2 staff with the same strain
- RCAs well under way
Jan 4th 2008

National press;
- “Superbug kills 2 new mums” etc..
- Media “experts” implied problems with hospital cleanliness, infection control etc
- Our press strategy worked well until the word “coincidence” was used on local TV
- Abusive blogs, e mails etc etc...

Jan 2008 – May 2009

- Intermittent peaks in publicity
- RCAs
- Independent external investigations
- Reports given to families, coroner etc
- Coroner’s investigation
- Inquests May 2009
Inquests May 2009

- No route of transmission established
- We were found to have made mistakes and have deficiencies in systems, but to have done everything which could reasonably be expected to investigate
- We were commended for our approach to the investigation by the Coroner and the families’ legal teams
- The media gave us reasonable reports
- We published the investigation report on the internet (http://www.wehet.nhs.uk/index/ournews.htm?newsid=9231)

Outcome

- Numerous internal changes in systems
- New national guidance on managing GAS clusters published May 2010
- Atypical presentation of GAS highlighted by the subsequent confidential enquiry)
What went well*

• Being open
• Patient and family support
• A proactive media strategy
• Media training
• The independent review

*…considering the tragic circumstances for 2 families

What could have been better

• Staff support
• Having a plan
• Our capacity to respond was very stretched due to;
  – An inexperienced leadership team in transition
  – Christmas holidays
Staff

- I didn’t adequately recognise the trauma for staff at all levels;
  - Frontline
  - Senior clinical leaders
  - Organisational leaders
- This was aggravated by the investigation and external publicity

Staff support

- I had experienced the “second victim” role before..
- …but was not really aware of systematic work in this area
- For me, it felt very personal (which probably impaired my ability to recognise and respond to others)
IHI experience

- IHI regularly get asked to help organisations across the US facing similar crises
- A framework for response has been developed drawn from this experience and from the business literature

www.ihi.org

Respectful Management of Serious Clinical Adverse Events

What’s Your Crisis Management Plan?

www.ihi.org
Recurrent themes

- Serious crises are more common than most of us acknowledge
- We tend to regard each as unique, which impairs our ability to learn from them, but...
- ...their management has many common elements
- So it is possible to plan for them

IHI experience

- Most organisations;
  - Don’t plan
  - Regard each crisis as unique
  - Make matters worse by their response
  - Don’t learn
Key elements of clinical crisis management

• Advance planning;
  – 75% of required actions are predictable and can be planned for

• Priorities, in this order;
  – Patients and families
  – Staff
  – Organization

• Communication, investigation, learning
Acknowledgements

The families of AK and JP
Alison Huggett, Louise Halfpenny, Katrina Tanner, Matthew Dryden, Paula Shobbrook; all previously WEHCT
Jim Conway, Frank Federico, Blair Sadler; all IHI
The Health Foundation

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Questions
Second victims of clinical incidents and errors

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Medical error: the second victim

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error. Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that “doctors are only human,” technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have confided with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that “it will never happen again.” Paradoxically, this approach has diverted attention from the kind of systemic improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors; they are the second victims.

Virtually every practitioner knows the sickening realization of making a bad mistake: You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonize about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient’s anger. You may become overly attentive to the patient or family, fearing the failure to do so earlier and, if you haven’t told them, wondering if they know... 

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticizing,” reassurance from colleagues is often grudging or qualified. One reason may be that learning of the failings of others allows physicians to divert their own past errors among

Wu, Albert. BMJ 18/03/2000
Second victim

- Clinicians involved in errors or adverse events who feel traumatized by their experiences
- They frequently feel personal responsibility for the patient outcome
- They may feel as though they have failed the patient

Scott 2009; Qual & Saf in Healthcare; 18; 325-30
Second victim effects

• Acute stress reactions (days to weeks)
  – Numbness, anxiety, sleep disturbance, grief, 
detachment, loss of trust, lack of concentration, 
poor memory
• Longer term effects
  – Shame, guilt, anger, self-doubt, flashbacks, 
irritability (similar to PTSD?), depression, 
behavioural change, drug and alcohol abuse etc

Severity of effects related to…

• The severity of the incident
• The characteristics of the patient
• The attitude of clinical colleagues
• The conduct of the enquiry
• Legal proceedings
• The relationship with the patient
Consequences

• Patient safety risks
  – Immediate aftermath
  – Longer term consequences for safety culture, openness, team-working, defensive practice, disruptive behaviour, working relationships etc

• Staff health, welfare, recruitment & retention

Trajectory of recovery *(Scott 2009)*

- Chaos & accident response
- Intrusive reflections
- Restoring personal integrity

- Obtaining emotional first aid
- Enduring the inquisition

- 6. Moving on
  - Dropping out
  - Surviving
  - Thriving

- Thriving
Survey of RCP Members 2013*

- 1755 responses
- 37% female
- Mean age 47 years
- All parts of UK
- All medical specialties
- Broadly fits the profile of NHS consultant physicians

*Clinical Medicine Dec 2014
Psychological effects of involvement in a safety incident

<table>
<thead>
<tr>
<th>Outcome</th>
<th>%</th>
<th>N</th>
</tr>
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<tbody>
<tr>
<td>Lower confidence in ability as a doctor</td>
<td>63.2</td>
<td>886</td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td>59.9</td>
<td>840</td>
</tr>
<tr>
<td>Reduced job satisfaction</td>
<td>48.5</td>
<td>681</td>
</tr>
<tr>
<td>Affected relationships with colleagues</td>
<td>25.5</td>
<td>358</td>
</tr>
<tr>
<td>Damaged professional reputation</td>
<td>20.1</td>
<td>282</td>
</tr>
<tr>
<td>Other personal or professional outcomes</td>
<td>15.8</td>
<td>221</td>
</tr>
<tr>
<td>Anxious about potential for future errors</td>
<td>81.5</td>
<td>1192</td>
</tr>
<tr>
<td>Generally distressed (e.g. depressed, upset, angry)</td>
<td>73.6</td>
<td>1077</td>
</tr>
<tr>
<td>Generally anxious (e.g. nervous, panicky, tense)</td>
<td>68</td>
<td>995</td>
</tr>
<tr>
<td>Negative towards yourself (e.g. shame, guilt, feeling incompetent)</td>
<td>27.3</td>
<td>399</td>
</tr>
<tr>
<td>More confident in your abilities (e.g. effective, efficient, competent)</td>
<td>7.5</td>
<td>110</td>
</tr>
<tr>
<td>Determined to improve (e.g. determined, resourceful, strong)</td>
<td>80.6</td>
<td>1179</td>
</tr>
</tbody>
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8% reported severe feelings of distress
4% reported severe anxiety

Sources of support

- Formal mentor 5.5%
- Family and friends 66%
- Peers 85%

84% had supported a colleague
87% would use a formal mentor if they had one
Incident reporting

- 80% had used NHS incident reporting systems
- 28% were satisfied with the way it had been dealt with
- 25% admitted being involved in an incident which they knew they should have reported, but didn’t

What can we do?

As leaders and professional bodies
As organisations
As individuals
  - The second victim
  - Colleagues
What can we do?

“Abandon blame as a tool and trust the goodwill and good intentions of the staff”

As leaders and professional bodies

- Recognise and publicise the concept, and that….
  - it’s primarily a patient safety issue
  - something can be done
- Promote mentorship for clinicians
- Promote work to understand the best approaches to support within a wider learning culture
- Model expected behaviours
As organisations

• Build structures into incident responses to;
  – Recognise and mitigate the potential risks to patients after an incident
  – Recognise and support second victims
• Promote and model a (genuinely) open, transparent, non-judgemental reporting culture

As individuals

Colleagues
– Offer informal support to colleagues who may be potential second victims
– Recognise effects in yourself and seek help early

Summary

• Second victim effects are common
• They affect clinicians across the spectrum
• This is;
  – Dangerous for patients
  – Harmful for clinicians
  – Bad for the service
• Something can be done to reduce the risks

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Take home messages (1)

Most organisations;
- Don’t plan
- Regard each crisis as unique
- Make matters worse by their response
- Don’t learn
Take home messages (2)

Be prepared;
- Make an organizational plan
- Make a personal plan (media training, support networks, know what your role would be)

Be proactive
- Investigate “cultural” warning signs and “weak signals”
- Ensure that a robust infrastructure exists

Take home messages (3)

• Deal with priorities in this order
  • Patients and families
  • Staff
  • The organization
• An open, transparent approach at every stage is not only the right thing to do but will enhance the organization’s reputation and help you learn and develop
Before you go........

• Thank you for participating in the minicourse
• Take 1 minute to write down two things that you will change or try as a result of what you’ve heard today
• Be prepared to share this with others

E mail us for slides and references

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