Institute for Healthcare Improvement

Planning for a Clinical Crisis

Preparation is critical to responding to events you hoped would never happen.

Two new mothers die within 24 hours of each other in your postnatal ward. A staff member in your children's hospital is arrested for possession of indecent images of children. A patient dies following an accidental chemotherapy overdose. Inadequate sterilization processes are found to have put hundreds of patients at risk.

All healthcare organizations experience serious clinical crises such as those that harm or potentially harm patients, traumatize staff and put the organization's reputation at risk. The response of the organization and its leaders, as much as the incident itself, can help define how the organization is viewed.

The most successful leaders have become skilled at responding respectfully to a crisis and treating it as an opportunity to learn and improve rather than an excuse to react and defend the status quo. Successful leaders don't wait for a crisis to strike; they plan for it in advance. Still, the majority of leaders are not prepared for crisis situations.

Based on its experience of helping healthcare organizations in the United States and internationally, and drawing on lessons from business literature, the Institute for Healthcare Improvement (IHI) has developed tools to help organizations and leaders manage serious clinical crises, learn from them and reduce the risks of having other crisis events.

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Common Features of Crisis Events

Serious clinical crises happen to all organizations, even the best. Although all crises have their own unique characteristics, it is remarkable how many features they have in common. For example, most aspects of what's needed to effectively manage a serious crisis are predictable and can be planned for, but, despite this, most organizations don't have a crisis management plan in place. Organizations are judged as much by their response to a crisis as by the crisis itself; choosing a proactive, respectful "systems approach" differentiates a good response from an average or poor one.

Organizations that take a systems approach to investigating crises find that numerous system failures at every level contribute (even in circumstances where there is clear individual failure or wrongdoing). Addressing these systems failures reduces risks for the future.

Advance Planning

Most healthcare organizations have plans for major incidents such as natural disasters and other external catastrophes, but few have plans for serious clinical crises. The approach IHI takes to help organizations is anchored in a work plan that prompts specific actions in the first hour, day, week, month and beyond. The plan supports the early formation of a crisis management team, whose membership is established in advance. Key themes of the planning process include engaging leadership, recognizing priorities, communicating internally and externally, investigating what has happened, and learning to avoid future crises.

Engage Leadership

Because a hospital's governing body (board of trustees or equivalent) is ultimately accountable for quality and safety, it should be informed about a clinical crisis and engaged in managing it from the outset. However, there's no substitute for visible, immediate and ongoing CEO and other

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C-suite leadership. This signals to patients, families, staff and the wider community that the incident and its investigation are being taken seriously. This is not a time for delegation.

The CEO is usually faced with the need to make decisions in an atmosphere of uncertainty and in rapidly changing circumstances. Business literature, such as Bill George’s *Seven Lessons for Leading in Crisis* (Jossey-Bass, 2009), recognizes that the wrong CEO response can cause a bad situation to become worse (see “8 CEO Attitudes That Make Matters Worse” on this page). This has been especially evident in healthcare.

**Recognize Priorities**

When a crisis occurs, senior leaders have a responsibility to give their undivided attention to everyone who has been affected. The list begins with patients and families, then immediate staff and then the wider organization.

Early, open and respectful communication with those who have been harmed, along with appropriate statements of sorrow, regret and apology, start to re-establish trust. The concept of the staff member as a “second victim” is well recognized in patient safety literature (a good example is the article “Medical Error: The Second Victim” by A.W. Wu in the March 18, 2000, issue of *BMJ*). Health professionals go through a range of emotions when involved in safety incidents, including regret, fear, shame and guilt. In the heat of the moment, leadership teams can fail to recognize this. Staff need immediate and visible support, and they need to feel that they will be treated fairly without leaders or colleagues jumping to conclusions. Most staff members do not come to work to harm patients. Likewise, most patients who have been harmed do not want punitive action taken against staff; rather, they want an apology and assurance that steps have been taken to reduce the risks for future patients.

**Communicate Internally and Externally**

Early communication from a senior source in the organization helps stakeholders make sense of what has happened. Leaders need to frame the core message and reconcile the various requirements from their organizations’ legal and communication departments.

Ongoing communication needs to be coordinated by senior staff members whose words and actions are perceived as credible. The first news stories frame all subsequent stories; rumors and misinformation will fill a vacuum, especially in the age of e-mail, Twitter and other electronic media. Patients and families, staff and the wider community will monitor communication closely, but so too will regulators, government, business partners, board members and competitors. Stakeholders should hear directly and frequently from the organization and should not have to rely on media to get information about a crisis.

**Investigate What Has Happened**

A root cause analysis should begin...
within 24 hours of the crisis and should include executive leadership, frontline staff and, if possible, patient and family representatives. This systematic approach to analyzing a serious and unintended clinical crisis to determine contributing factors must be fair and balanced; it must be integrated into the entire organization’s quality and safety agenda; and it must have the confidence of patients, staff and the wider community. Many organizations find that when a crisis strikes, these processes tend to be slow and incomplete. There’s great opportunity to do better here.

Learn to Avoid Future Crises
Serious organizational crises, as much as individual patient safety incidents, are nearly always the result of a succession of events rather than the failure of an individual or a single system. This “Swiss-cheese model,” as described by Jeremy Stranks in his book Human Factors and Behavioural Safety (Butterworth-Heinemann, 2007), means that there are usually lessons for many parts of the organization, including areas that are remote from where the problem has arisen.

For example, an investigation into maternal deaths at a hospital uncovered problems with rosters for laboratory staff, poor processes for communication with regulators and inadequate legal support available during holiday times. None of these had a bearing on the crisis itself, but all were deficiencies that might have put patients or the organization at risk in the future. A systematic approach for capturing and disseminating lessons learned from crises allows teams to identify and deal with defective systems across organizations, thus having far wider potential impact.

It is possible to anticipate and plan for a clinical crisis. Although each crisis will have some unpredictable, unique features, the key elements of a response are predictable and common to all crises. Organizations that have a plan that they test and simulate are in a much stronger position when a crisis strikes. By demonstrating a systematic, developmental approach to crisis management, they immediately begin to regain some lost credibility with patients, staff and external stakeholders—and will ultimately benefit from turning a disaster into an opportunity.

James B. Conway, FACHE, is an adjunct faculty member of the Harvard School of Public Health and a senior fellow at IHI. He can be reached at jconway@IHI.org. Blair L. Sadler, JD, is a senior fellow at IHI and a member of the faculty at the University of California, San Diego, Schools of Medicine and Management. He can be reached at bsadler@chsd.org. Kevin Stewart, MD, FRCP, works with the English National Health Service and is a recent IHI Fellow. He can be reached at kevin.stewart@wehct.nhs.uk.

Editor’s note: To learn more about IHI’s tools for helping leaders manage and reduce crisis events, visit http://tinyurl.com/IHIEffectiveCrisisMgmt.