

A Medication Problem

- 5 month old infant with complex congenital problem
- Sunday morning, 3AM
- Experienced pediatric ED nurse; new orientee
- Pediatric resident
- Hectic ED....

A Medication Problem

- Fever + immuno-compromised = antibiotic
- $10\text{mg/kg} \times 6\text{kg} = 600\text{mg IV}$
- “This seems like a lot”
- Repeatedly interrupted; child in next room with a seizure; orienting new nurse
- 3:30AM
- At 7:00AM, medication orders reviewed...

Dr Frush – what should we do??

Considerations

- Event review, leading to improvement
 - Systems issues
 - Human factors and behavioral choices
- Disclosure
 - Transparency and trust
 - Importance of prevention in the future
- Achieving and sustaining change
 - Locally; broadly

Moving from a Culture of Blame to a Culture of Accountability

- Reporting errors and adverse events
- Reviewing adverse events
 - Identify systems issues
 - Identify individual choices and behaviors
 - Just Culture context to manage behaviors
 - Simple human error
 - Risk-taking
 - Blatant, reckless behavior

Disclosure, Transparency and Trust: What Do Patients and Families Want After a Medical Error ?

- * An honest explanation
- * An apology
- * To know we'll care for them
- * To know we're doing all we can to prevent it from happening to anyone else

Do physicians disclose errors?

- JAMA 1991: 76% of house officers had not disclosed serious error to a patient:
 - fear of malpractice suit; “awkward, uncomfortable” task
- NEJM 2002: only 30% of respondents who experienced a medical error said that the involved healthcare professional had informed them of the error
- JAMA 2005: survey of hospital leaders
 - 100% would disclose error causing serious harm
 - 85% would disclose error causing moderate harm
 - 45% would disclose error causing minor harm

Disclosure and Transparency

- **Non-abandonment of patients and families**
 - No one said “I’m sorry”. Do they have any idea how it feels to be hurt by someone you thought you could trust? Do they care?
 - Who can I talk with to be sure they really understand the need for change? I don’t really want to go to a lawyer or the press, but what are my options?
- **Non-abandonment of healthcare providers**
 - I’m a physician. If “they” have done this to me, then I’ve done this to others.
 - How do we help healthcare providers heal?

Creating a Culture of Safety: Honesty, Transparency, Disclosure

Dr. Frush, what should we do??

- Leadership

- Model the behavior
- Systems issues, behavioral choices

- Transparency, Disclosure

- Build a bridge, re-establish trust
- Follow through on caring for child

Creating a Culture of Safety: Disclosure, Transparency and Trust

- *It's hard:* we have no training in disclosure
- How do we help clinicians?
 - Leadership: we're going there
 - Managers: have knowledge and tools to help
 - Individual clinicians: provide an example and strong support

Disclosure of Unanticipated Outcomes and Medical Error

- Institute for Healthcare Communication
- Train-the-trainer model
 - Lead Physician training other physicians
- Situation manager training
 - Disclosure team
- Faculty, staff, residents, students
- Coupled with team training in healthcare professional schools

“Nothing about me without me”



Why Use Stories?

- Because they are personal
- Stories paint pictures
- They connect us with our own experience
- Anchor the conversation with our common goal – safe care for every child every time

Hallmarks of an Effective Story

- I can see myself in it
- Listeners don't get lost in the technical details
- Connects on an emotional level
- Frames our common goal

Engaging Our Culture

- Bottom up – good people working in a complex environment full of surprises and uncertainty, fatigue, multitasking, interruptions.
- How do we make it safe to have the conversation?
- If you can't talk about it, you get to do it again

What's the Answer?

- Everybody in the same movie
- Have a plan – share it
- Effective team formation: set the stage, continuously invite the other team members into the conversation
- Tools and behaviors: structured language / SBAR, critical language, psychological safety, effective leadership