Idea Three: Put a Face on the Problem, Starting at the Board.

Patient stories, especially stories about harm, are a powerful way to engage the hearts of Trustees in quality and safety issues. An emerging "best practice" for Boards is to hear the stories of patients and families on a regular basis, perhaps at every meeting. This primer is intended as a practical guide to Boards on how to bring patient stories into their regular agendas. Four methods of bringing patient stories forward are summarized, beginning with the easiest and least controversial, and progressing to more difficult, but perhaps more powerful methods.

If none of these has been a regular practice of your Board, it is strongly recommended that you take action to implement at least one of these methods within the next few months.

1. Brief story told by staff

   This method can be used at any meeting, and its principal purpose is to illustrate a data element that the board will be reviewing as a part of the meeting. The point is to make sure that the board *viscerally* understands the personal impact of a safety defect such as a central line-associated bloodstream infection or a decubitus ulcer, rather than just seeing a run chart of rather abstract data.

   The story should be told briefly, without too much technical detail, in plain language. It can be told by any of the staff who usually attend the Board or Board Committee meeting. Following is an actual example of such a story as told to a Board Quality Committee

   As you know, we spend the first 5 minutes of every meeting with a brief story about a patient's care. The purpose of these stories is to illustrate the sorts of things that can go wrong in care, so that you can have a better understanding of the data that we show you about quality and safety mishaps at these meetings. It is not our purpose in telling the story that the Quality Committee should work on coming up with solutions to these kinds of problems, or get into lots of detail about any one patient's experience.

   Just to remind you, we don't use the names of patients, family, physicians or staff in these stories.

   Today's patient story is about a 79 year-old woman who came in to our hospital with congestive heart failure, or CHF. Shortly after admission, she was placed on several medications and treatments for her CHF. One of the medications (a beta blocker) was prescribed in a fairly strong dose—perhaps more appropriate for a younger person. Our systems—pharmacy, nursing, computer order entry—didn't detect that the dose was too strong for an elderly woman. Over the first 12 hours in the hospital, as the medications took

effect, her blood pressure dropped lower and lower (a side effect of the medication). During that 12 hour period, there were several "handoffs" of responsibility for this woman—from one nursing shift to another, and from one physician "shift" to another. The team caring for her was busy caring for lots of other sick patients. In the midst of all this, concerns about her falling blood pressure were not transmitted from one shift to the next. Her BP eventually reached such a low point that the patient was in shock, and she went into cardiac arrest. A code blue was called but was unsuccessful, and the patient died 15 hours after admission.

The slide on the screen is the current "run chart" for mortality rate at ____ Hospital. This woman would have been one of the deaths—perhaps a preventable one—that occurred during this month here—November—and is an example of the sort of issue that we're working on when we say we're trying to reduce "preventable deaths" at ____ hospital. Not all deaths are preventable, obviously, but this one probably was. Any questions before we go on with the quality report, in which we will discuss our overall strategy for reducing the likelihood of these sorts of preventable deaths?

Important elements of such stories are:

- It's a story about harm that occurred in *this* hospital, not some other hospital somewhere in the country.
- The story is recent, not from years ago (so no one can claim "We *used* to have that problem but now it's fixed.")
- The story illustrates systemic issues, rather than individual negligence.
- The story is scripted, as above (actually written out)
- The story is directly relevant to data being reviewed by the Board or Committee at *that* meeting.

2. <u>Short video tape of a patient or family member telling about an experience.</u>

Another way to bring patient stories to the Board is to do a videotaped interview of a patient or family member, after a harm event. The focus of the interview is to understand the effect of the harm event in personal, and to transmit the visceral impact of the event to the Board. The videotape can also illustrate an element of the safety data that the Board is overseeing. There are two basic questions in the interview

- Tell the story of what happened, as you experienced it.
- Tell us how what the impact of this event has been on your life.

This method requires more advance work from hospital staff. Interviewees must be selected, the interview scheduled, the videotape must be edited, and so forth. But these tapes can be very powerful mechanisms to "activate" a Board on issues of quality and safety.

Example: Before the annual Board retreat, hospital staff interviewed the husband of a 71 year-old woman who had experienced a surgical site infection after a knee replacement. The husband described how they learned of the infection, the prolonged pain and poor physical function that resulted, the uncertainty and fear, and the draining, constant demands on the caregiver (the husband). He ended the interview with "…and the worst part was that I was unable to plant our garden this year, because I was so busy taking care of all these other things for her. It's the first year in our 49 years of married life that I haven't planted the garden. It's been my pride and joy, but not this year."

And then the Board went on to discuss the data for the hospital on surgical site infection rates, and engaged in a vigorous conversation with medical staff leaders and administration about what was being done to reduce such infections, with a far greater sense of urgency than prior to the video.

3. <u>Commissioned "deep dive" interview of a patient or family member after a serious harm event</u>

In this method, the Board asks the CEO, along with one or two key Board members, to do a personal interview with the patient and family members involved in a recent serious harm event, and also to conduct similar interviews with the nurse(s), pharmacist(s), physician(s) or others who were directly involved in the event. This process might take a few weeks to complete, after which the Board will ask those who did the interviews to present a report to the Board, followed by a deep discussion of the implications for the Board.

This process has two purposes. One purpose is to catalyze the personal transformation of CEOs and Board leaders. Simply stated, most human beings cannot participate in this difficult, painful interview process and emerge unchanged. The second purpose is to provide an opportunity for the Board to develop a much deeper understanding of the cultural and systemic forces that lead to tragedies.

How? The process is simple to describe, difficult to execute. The steps include:

- The Board must "commission" the deep dive. This can be initiated by the CEO, or by the Board, but it is a formal request of the Board.
- The Board must designate its representatives in the process (usually, the Board Chair and the Chair of the Quality Committee, if there is one)
- An event must be selected (it is best if this is an preventable, serious, recent harm event)
- Patient and family permission must be obtained
- Staff members and physicians at the "sharp end" of the event must be contacted and scheduled for interviews
- Interviews must be conducted (these are often emotionally laden, and must be focused on listening to those being interviewed for two principal

elements: content (what happened) and emotion (how do you feel about what happened.)

- A meeting of the Board should be devoted to hearing and discussing the report of those who did the interviews, and translating any lessons learned into improvements of the system.

4. Full Board conversation with a patient or family member

In some circumstances, the Board might wish to invite a patient or family member to meet with the Board itself, so that the Board can hear directly about the patients' view of what happened, and how it has affected them. This is obviously a very difficult moment for the Board, especially if the event involves preventable death or permanent injury, and if liability risk is involved, as is often the case. But such meetings can be extremely important to the evolution of the Board's understanding of the issues faced by the organization, and can also be a vital first step toward healing of the breach of trust and confidence that these sorts of event represent to patients and families. One key outcome of such conversations is that patients or family members would say: "The Board listened to me, and is committed to take steps to ensure that this won't happen again."

There are no good scripts for how to have such meetings, but there are some excellent guides to medical apologies that should imprint the conversation, such as the Harvard Risk Management Foundation's approach.