

# Leadership Response and Learning From A Tragedy

*The Dana-Farber Cancer Institute  
Patient Safety Journey 1995-2005*

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## Outline

- Through the Lens of DFCI
  - Leadership's responsibility and power
  - Relentless vigilance
  - The multiple victims of error
  - Design of systems to support of safe practice
  - Interdisciplinary practice and team work
  - Patient and Family Centered Care
- Where Are We Going?

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### **DANA-FARBER ADMITS DRUG OVERDOSE CAUSED DEATH OF GLOBE COLUMNIST, DAMAGE TO SECOND WOMAN**

When 39-year-old Betsy A. Lehman died suddenly last Dec. 3 at Boston's Dana-Farber Cancer Institute, near the end of a grueling three-month treatment for breast cancer, it seemed a tragic reminder of the risks and limits of high-stakes cancer care. In fact, it was something very different. The death of Lehman, a Boston

Globe health columnist, was due to a horrendous mistake: a massive overdose of a powerful anticancer drug that ravaged her heart, causing it to fail suddenly....

The Boston Globe 3/23/1995

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## Key Learning in Journey

- The responsibility and power of all leadership [trustee, clinical and administrative] over safety throughout the ten years
- The need for relentless vigilance to safety, risk, error, near-miss, harm
- Addressing the multiple victims of error
- The crucial role the design of systems and application of technology play in support of safe practice by excellent staff
- The synergy of interdisciplinary practice and team work
- Patient and Family Centered Care

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## What Does DFCI *Executive* Leadership Try to Look Like

- Personally lead and be accountable for ongoing safety program
  - Model the way and mobilize the effort
  - Be a student of safety
  - Create urgency
- Establish a non-punitive environment; Set the tone
- Understand when it is and isn't a democracy; the work of leaders
- Taking risks in the name of the patient, family, and staff
- Ensure interdisciplinary incident review; At the table
- Transparency; Honestly discuss safety: Board and throughout organization
  - Hardwire into meetings: Board, MSEC, EMG
- Focus, focus, focus; measure, report
- Probe staff on what feels unsafe

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## Relentless Vigilance

- Staff committed to / vigilant in safe practice
- Safety, risk, harm openly discussed and hardwired in all standing meetings
- Ongoing meetings of a multidisciplinary team concurrently reviewing all incidents and errors and trending data for patient-specific and system-wide follow-up and improvement.
- Timely root cause analyses over 8 years with systematic follow-up procedures
- Educate interdisciplinary staff on learning from RCA
- Patient Safety Rounds in- and out-patient care
- Culture / staff survey driving improvement

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## Design To Support Safety



- > Informatics:
  - Partners, DFCI, and other clinical applications:
    - EMR, COE, pharmacy, labs, radiology, pathology
  - Online access to current version of all protocols
  - “Safety over Convenience” Philosophy
  - Standardized all non-protocol chemo order sets
  - System-wide drug-drug, allergy systems
  - Intervention logging systems

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## Addressing Multiple Victims



- > Practice of disclosure for 10 years
- > Principles of a fair and just culture approved by Board of Trustees
- > Immediate access to support for all staff at the sharp end of error
  - Burden of the near-miss
- > Staff inclusion in RCA to assure about what happened and not who did it

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## The Tension of Accountability



- > When a patient is at the sharp end of an error, who is accountable?
  - ❖ Is it all about systems?
  - ❖ Where does individual accountability, responsibility, and competence fit it?
  - ❖ Where does shared accountability fit in—do we have a responsibility to each other?
- > We have to figure it out together
- > Our culture must be fair and just [non-punitive]

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## Managing Risk – The Three Behaviors

Normal Error	At-Risk Behavior	Reckless Behavior
<p><i>Product of our current system design</i></p> <p>Manage through changes in:</p> <ul style="list-style-type: none"> <li>•Processes</li> <li>•Procedures</li> <li>•Training</li> <li>•Design</li> <li>•Environment</li> </ul>	<p><i>Unintentional Risk-Taking</i></p> <p>Manage through:</p> <ul style="list-style-type: none"> <li>•Understanding our at-risk behaviors</li> <li>•Removing incentives for at-risk behaviors</li> <li>•Creating incentives for healthy behavior</li> <li>•Increasing situational awareness</li> </ul>	<p><i>Intentional Risk-Taking</i></p> <p>Manage through:</p> <ul style="list-style-type: none"> <li>•Disciplinary action</li> </ul>

Frankel and Marx, 2003

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## And A Supporting Vision: Fair and Just Culture

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

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## Interdisciplinary Practice / Team Work

- Physician Nurse leadership model in care operations and systems design
- Interdisciplinary teams oversee all aspects of care at all times
- Emerging areas:
  - Teamwork training
  - Structured communications

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## Patient and Family Centered Care



DANA-FARBER  
CANCER INSTITUTE

- Mainstreamed patient and family centered care model
- Adult and Pediatric Patient and Family Advisory Committees for 8+ years
- Patient and family participation in operating committees, as well as in all design, measurement, assessment, and improvement efforts

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## Patient and Family Centered Care

DANA-FARBER  
CANCER INSTITUTE

- People are treated with dignity and respect
- Healthcare providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful
- Patients and family members build on their strengths by participating in experiences that enhance control and independence.
- Collaboration among patients, family members, and providers occurs in policy and program development and professional education, as well as in the delivery of care

*Institute for Family Centered Care*

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## Overarching Structures & Processes

DANA-FARBER  
CANCER INSTITUTE

- Committees:
  - ❑ Board Quality Committee
  - ❑ Patient Safety Committee
  - ❑ Strategic and Building Planning
  - ❑ Operating Committees
  - ❑ Patient Education
- JCAHO
- Leadership Interviews
- New Employee Orientation
- Side by Side
- Resource Centers
- Rescue events
- NPSF & IHI meetings



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Adult Patient and Family Council  
Dana-Farber / Brigham and Women's Cancer  
Center



- Rounding
- New patient access
- Task Force on Disclosure
- Renovations / Process Redesign
- Advocacy Days
- Working on the Wait
- Customer Service Training
- Falls Task Force

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Pediatric Patient and Family Council  
Dana-Farber / Children's Hospital Boston Cancer Care



- ER Fast Track
- End of Treatment
- Renovations / Process Redesign
  - Patient Flow
  - Out-patient
  - In-patient
- Insurance
- Diversity

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## Results



- Significant reduction in errors causing harm
- Improved levels of reporting of incidents and near-misses
- Low rates of harm when compared to peers
- High levels of staff satisfaction when compared to peers
- High levels of patient satisfaction when compared to peers
- High levels of clinical staff retention, low turnover, low vacancy rates
- Significant increases in patient volume over the 10 year period
- Continued improvement in financial effectiveness of clinical operations
- Extensive local and national partnerships with patient safety community
- External recognition of work for change, learning, dissemination

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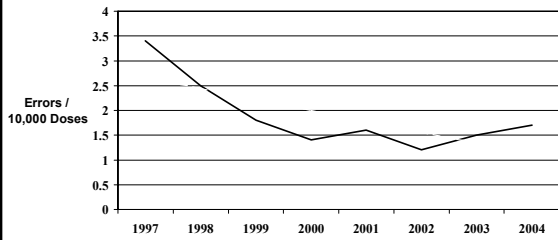
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## Medication Safety at DFCI Outpatient Errors Reaching Patients



Courtesy L. Leape

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## WITH WORK, DANA-FARBER LEARNS FROM '94 MISTAKES

Author(s): Scott Allen

A decade after Lehman's death, on Dec. 3, 1994, Dana-Farber has emerged as one of the most safety-conscious hospitals in America, with computers that trigger alarms at potential overdoses, a hyper-vigilant error-reporting system, and a top executive who pushes measures in pursuit of the old physician's promise to "first do no harm." Once a symbol of medicine's dark side, Dana-Farber's experience is now used in instructional brochures and videos.

The Boston Globe 11/30/2004

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## DFCI: A Culture of Safety *Some Reflections*



- Based in trust, human rights, and forgiveness
- Patient and family centered
- Supports staff, enabling and motivating the highest levels of performance
- Acknowledges high risk, error-prone nature of healthcare
- Ensures individual and shared acceptance of responsibility and accountability for safe delivery of quality care, risk reduction, care outcomes in a systems based approach
- Encourages and facilitates reporting and open communication about safety concerns in a fair and just environment
- Ensures organizational structures, processes, goals and rewards are aligned with improving patient safety [HRO]
- Learns from errors
- Shares stories of safety

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## Current Areas of Focus



### *Excellent – Not Perfect*

- Mitigating risks of new technology
- Patient gateway
- Hand Hygiene
- Bar coding / patient identification
- Communications / hand-offs / Team Training
- Center for Patient Safety
- Web based incident reporting system
- Diagnostic errors
- Supporting patients, families, and staff at sharp end
- Organizational assessment using Baldrige

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## Could Have Done Better



- Measurement
- Engagement of rank-and-file medical staff
- Engagement of those closest to the patient and family in learning
- Clinical research integration
- Publications
- Research

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"Do not go where the path may lead; go instead where there is no path and leave a trail"

Ralph Waldo Emerson

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Journey

➤Burden

➤Responsibility

➤Power

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