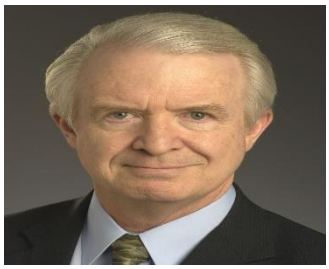
The Lessons Learned

2021 Presentation by John J. Nance, JD



In the aftermath of the international healthcare emergency caused by the Covid-19 Pandemic, few if any hospitals large or small have escaped having to deal with major systemic stress. In most cases, in addition to unleashing major unexpected financial challenges, the seismic challenges to clinical staff and all support services has spawned untold examples of how people rose to the occasion (or didn't), and how bedrock procedures and strategies were changed on the fly (and in some cases abandoned) to get the job done. All of this occurred against the backdrop of a massively challenged, frightened, and often polarized civilian population whose lack of collective knowledge and understanding of the factual science often made the hospital's job infinitely more difficult. There has been created, in other words, a major anthology in terms of how your institution dealt with all aspects of the Covid-19 challenge. Moreover, every salient aspect of that anthology (including the clinical, scientific, procedural, human, and financial history) holds untold lessons. Those lessons, if captured and examined appropriately, will light the way to far more realistic systemic and professional knowledge of how high reliability, just culture, patient safety, and the highest level of care are really achieved, *especially in your institution!*

Yes, this call for action is early, but decidedly not premature. Frankly, it's not news to any medical professional or administrator that we're still in the teeth of the battle, even though the vaccines are turning the tide. But with memories fresh and your often-exhausted workforce having plowed new ground in solving such a wide range of problems together, NOW is the time to begin mining that invaluable, experiential data in ways that will not disrupt, but *will* set the stage for a major learning experience. And, among the myriad advantages of planning and starting this process of lessons-learned examination - even while the ship of state is limping back to port - it will give to each of your people the crystalline message that *their* experiences and *their* ideas are, without question, invaluable. After all, the lessons of your experience are unobtainable elsewhere.

No military organization nor experienced high reliability enterprise would fail to have a structure for an "after-action" analysis of any major challenge or operation. In medicine, of course, many institutions are relatively new to the process of blame-free re-examination of negative clinical occurrences (given the opinion I share that M and M sessions and Root Cause Analysis meetings do not routinely rise to the level they could achieve in after-action analysis). In other words, even in the absence of the Covid-19 disaster, hospitals were working toward what could be most accurately described as the "NTSB (National Transportation Safety Board)

Method" in which blame is acidulously avoided and the focus becomes discovering everything that contributed to a negative result (not just highlighting one contributing factor). Interestingly enough, when things have gone brilliantly, this method works with equal alacrity to assist leaders and staff at all levels to understand why certain actions and procedures were successful, and then make certain they are incorporated into standard practice in the future, *whether such methods or procedures were part of the "way we had always done it" or not.*

What are we offering?

A package approach to do four vitally important things: 1) Extract the information, the stories, the changes and the experiences and structure them into a matrix of lessons learned; 2) Guide staff-wide or system-wide meetings and seminars to bring out important ideas and insights in a process that clearly values their experiences; 3) Assist leadership at all levels in finding reasonable and cost-effective ways of incorporating these lessons and ideas, or at the very least identify the points of conflict between the art of the possible and the recommended changes; 4} work with the C-suite and/or the board in institutionalizing the value derived from this project.

We understand that the term "High Reliability" has become to some an eye rolling phrase, but regardless of the reaction to the name, the concept and philosophy behind High Reliability status is unquestionably the best midwife of safety, effective practice, and staff satisfaction (inclusive of physician satisfaction). It is our considered opinion that the ways in which each institution achieved (or failed to achieve) high reliability in any clinically important area of practice during this unprecedented emergency offers an entirely new method of solidifying the systemwide acceptance and utilization of high reliability principles.

There is an old, familiar phrase, often uttered by someone touring a very old or established structure: "If these walls could only talk!" Well, your people are the walls of the institution, and they *can* talk – provided we have the will, and the know-how, to listen.

John can do this Virtual or is happy to speak in person now. Please contact Lori Carr to schedule your next presentation.

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