

## References and Bibliography: Effective Crisis Management

Augustine N. Managing the crisis you tried to prevent. *HBR On Point*. Summer 2009. Reprint 95602.

Boothman R, Anderson S. "Extreme Honesty: A Principled Approach to Adverse Events." Presentation at the Institute for Healthcare Improvement 21<sup>st</sup> Annual National Forum on Quality Improvement in Health Care in Orlando, FL. December 7, 2009.

<http://www.cmhc.com/media/handouts/29IH01/M24%20-%20Extreme%20Honesty.pdf>

Chafe R, Levinson W, Sullivan T. Disclosing errors that affect multiple patients. *CMAJ*. May 26, 2009.

Conway JB, Nathan D, Benz E, et al. Key learning from the Dana-Farber Cancer Institute's ten-year patient safety journey. In: *Am Soc Clin Oncol* 2006 Edition. 42nd Annual Meeting, Atlanta, GA, 2006:615-619. <http://www.dana-farber.org/pat/patient/patient-safety/docs/journey.pdf>

Conway JB. Could it happen here? Learning from other organizations safety errors. *Healthc Exec*. 2008 Nov-Dec;23(6):64, 66-7.

<http://www.ihl.org/IHI/Topics/LeadingSystemImprovement/Leadership/Literature/CouldItHappenHereLearningfromSafetyEfforts.htm>

Conway JB, Weingart SN. Leadership: Assuring respect and compassion to clinicians involved in medical error. *Swiss Med Wkly*. 2009 Jan 10;139(1-2):3.

<http://www.smw.ch/docs/PdfContent/smw-12574.PDF>

Crisis management: Master the skills to prevent disasters. *Harvard Business Essentials*. 2004.

Dutton J. Leading in times of trauma. *HBR*. January 2002. Product 8563.

George B. *Seven Lessons for Leading in Crisis*. San Francisco: Jossey-Bass; 2009.

Gladstone J. Executive decisions: Persuading CEOs to do the right thing during a crisis. *The Public Relations Strategist*. Summer 2009.

IHI. Communicating after an adverse event: Selected bibliography and resources.

<http://www.ihl.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/Tools/CommunicatingAfteranAdverseEventBibliolHITool.htm>

Note: Many other resources on disclosure can we found at [www.ihl.org](http://www.ihl.org)

Joint Commission. Sentinel Event Policies and Procedures.

[http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/se\\_pp.htm](http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/se_pp.htm)

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Lukaszewski JE. Establishing individual and corporate crisis communication standards: The principles and protocols. *Public Relations Quarterly*. Fall 1997:7-14.

<http://www.e911.com/monos/articles/Article,%20BBL,%20PR%20Quarterly,%20Establishing%20Individual%20and%20Corporate%20Crisis%20Communication%20Standards,%20Fall%201997.pdf>

Managing in a Crisis. *Harvard Management Update*. 2005. Reprint No. U0508d.

Massachusetts Coalition for the Prevention of Medical Errors: *When Things Go Wrong: Responding to Adverse Events: A Consensus Statement of the Harvard Hospitals*. March 2006. <http://www.macoalition.org/documents/respondingToAdverseEvents.pdf>

Medically induced Trauma Support Services. [www.mitss.org](http://www.mitss.org)

Munch D. Patients and families can offer key insights in root cause analyses. *Focus on Patient Safety*. 2004;7(4). <http://npsf.org/paf/npsfp/fo/pdf/Focus2004Vol7No4.pdf>

National Patient Safety Agency (UK). Being open: Communicating patient safety incidents with patients, their families, and carers.

<http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077>

Peto RR, Tenerowicz LM, Benjamin EM, Morsi DS, Burger PK. One system's journey in creating a disclosure and apology program. *Journal of Quality and Safety*. 2009 Oct;35(10):487-96.

PRSA. *The Public Relations Strategist: The Crisis Issue*. September 2009.

Roesler R. Supporting staff recovery and reintegration after a critical incident resulting in infant death. *Advances in Neonatal Care*. 2009 Aug;9(4):163-171.

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Health Care*. 2009 Oct;18(5):325-330.

Sorryworks Coalition. <http://www.sorryworks.net/about.phtml>

Zimmerman T, Amori G. Including patients in root cause and system failure analysis: legal and psychological implications. *J Healthcare Risk Management*. 2007; 27(2):27-33.