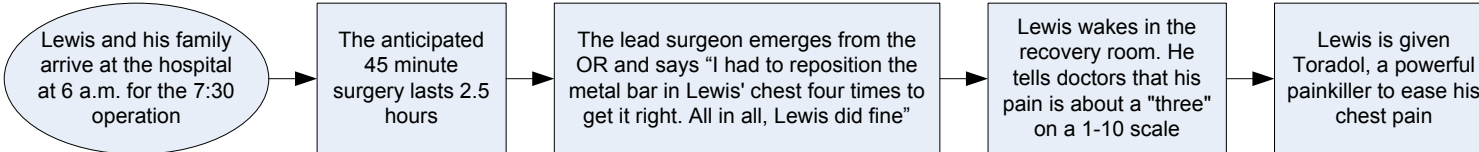


Lewis' Story – “It’s Hard to Kill a Healthy 15-Year Old”

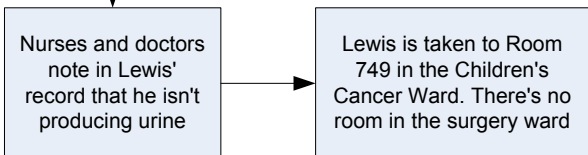


Lewis Blackman, was a healthy, gifted 15-year-old. He underwent elective surgery for *pectus excavatum* – a crease in the chest cavity

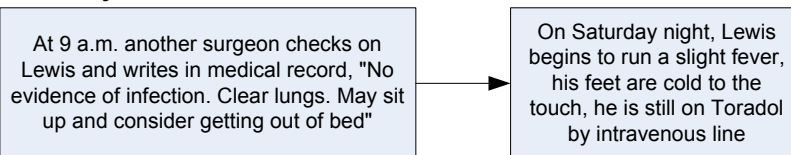
Thursday, November 2



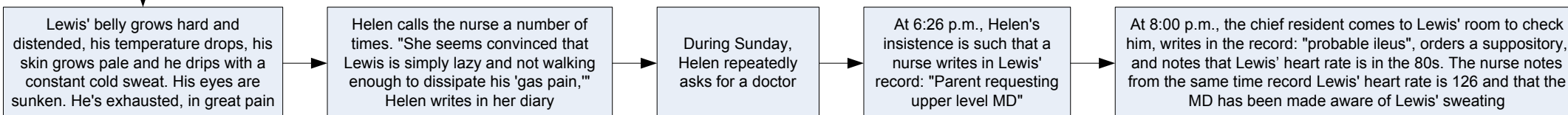
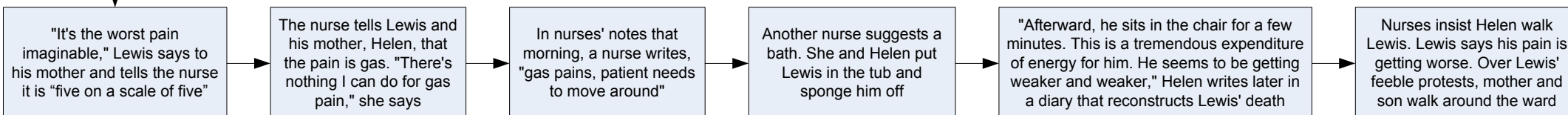
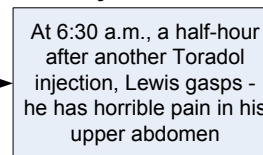
Friday, November 3



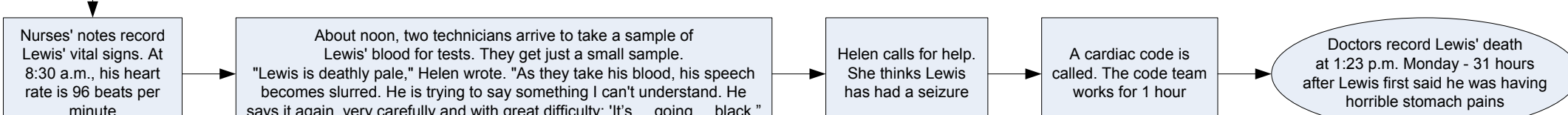
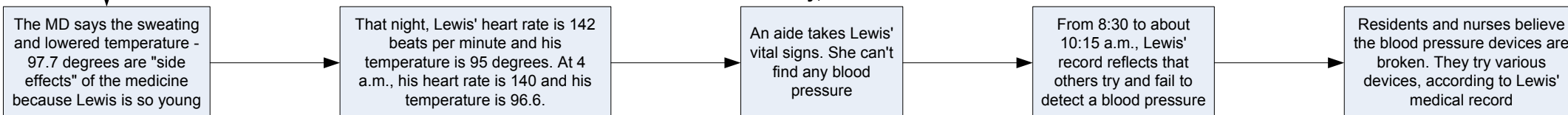
Saturday, November 4



Sunday, November 5



Monday, November 6



Where did the system fail Lewis and his family?

Use the following questions to guide your analysis of this event. Record your answers and thoughts in the space provided

- Where were the system failures in Lewis's care process related to **organization, environment, technology, work tasks, health care provider**?
- Where in the process of care did **incidents** (errors, near misses, adverse events, and harm) occur?
- Were their opportunities in the process of care to **repair physical damage? Repair relational damage? Repair emotional damage?**
- What are the key **learning points** and how do we learn from this incident to proactively prevent similar incidents from occurring in the future?

1. System failures:

Organization

Environment

Technology

Work tasks

Health care provider

Other

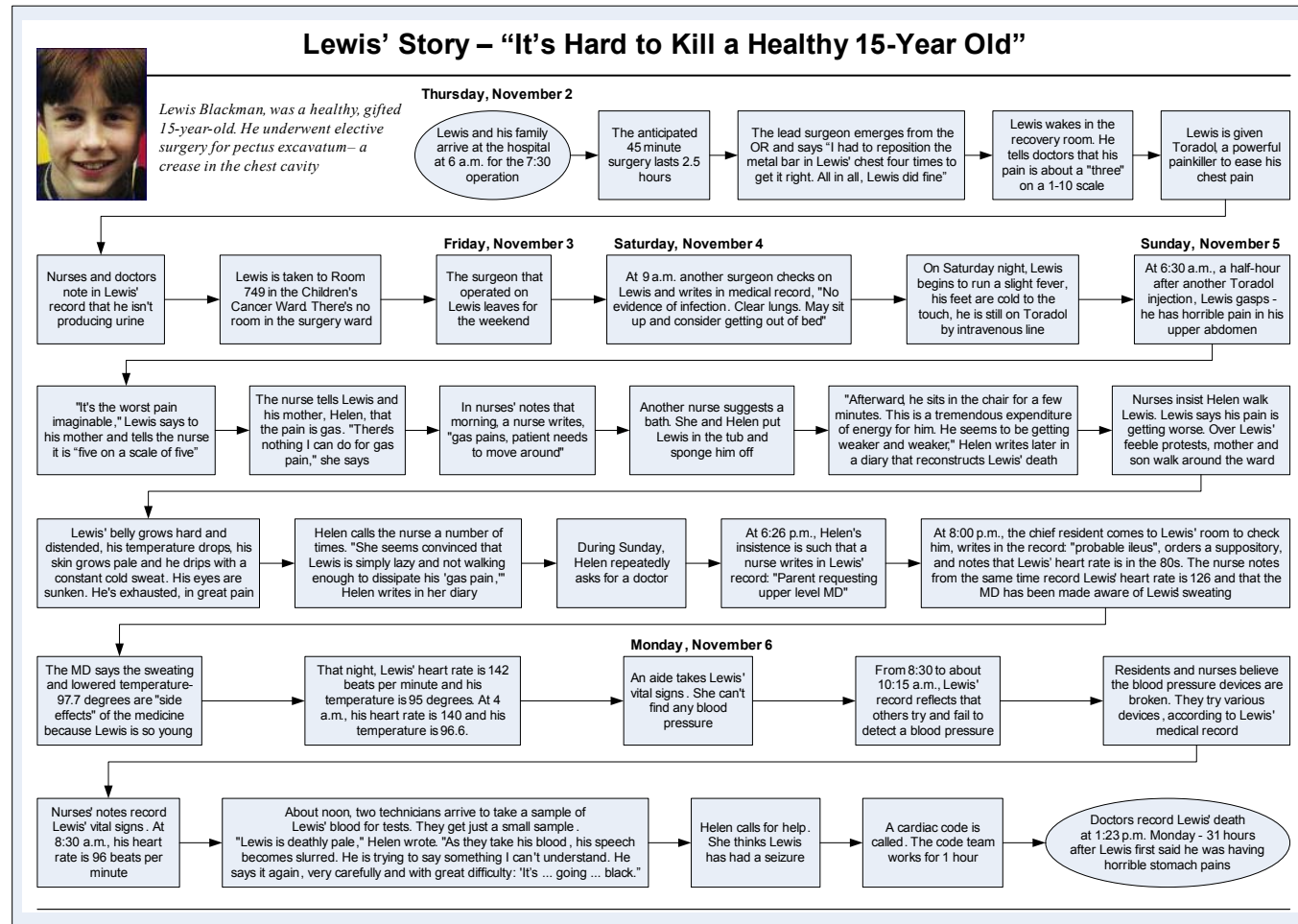
2. Incidents:

Errors

Near misses

Adverse events

Harm



3. Opportunities:

To repair physical damage

To Repair relational damage

To Repair emotional damage

Other

4. Key learning points for preventing similar events: