Video-Storytelling:
A Step-by-Step Guide

Introduction to a New Department
It is my pleasure to introduce a new department for The Joint Commission Journal on Quality and Safety. Tool Tutorial, as the name implies, presents selected tools that support effective and innovative work in quality improvement and patient safety. This department offers information about highly effective and innovative tools that readers may apply in their own improvement work—and to generate energy and enthusiasm for that work.

This department offers an exciting opportunity to explore and refine the “tools of our trade.” As craftspeople have taught us for hundreds of years, the quality and outcomes of work rely heavily on effectively using the best tools for the job at hand. Indeed, as tools have evolved, they have supported gifted craftspeople in perfecting their arts and realizing creative outcomes that were previously thought to be impossible. The intent of Tool Tutorial is to share knowledge, foster creativity, and support the wonderful work of those seeking improvement in quality and safety. In your hands, these tools may support exceptional results.

—Tina Maund, MS, RN

Introduction
Our first formal use of storytelling at Overlook Hospital as a method of supporting cultural change in health care dates to 1996. At that time, we experimented with brief interrupted clips of movies, with associated small-group dialogue and discussion. The clips were selected to provoke fresh thinking and perspectives around issues of leadership (for example, Wizard of Oz), patient satisfaction (The Doctor), cooperation (Babe), and change management (A Christmas Carol).

In 1999 we began to explore using video to support patient safety. We discovered that some of the vocabulary and conceptual frames involved in safety work could be identified in some Hollywood video clips. For example, It's a Wonderful Life contains a story of a pharmacy error, in which harm did not reach the intended patient. The clip serves as a rich matrix for discussion of latent factors, blame and nonblame themes, and process issues.

As our emergency department (ED) became an increasingly self-aware microsystem,¹ we began to meet monthly for 5- to 6-hour microsystem management meetings attended by large numbers of line and managerial staff. By 2000 we had established a culture in which patients were invited to share their stories, in person, at the meeting. Stories involved events that did not go as well as the patient had wished, and events that went exceptionally well. Private attendings and members of other hospital departments are invited to these meetings, not only to work on improvement of care processes but also to share stories.

In 2000 we produced the video “Patients’ Needs Come First.” The four emergency departments of Atlantic Health System (AHS) collaborated in developing the video. A call for stories concerning patient satisfaction led to 21 submissions, which were woven into 7 rich vignettes. The stories are intended to promote dialogue and motivate the will to improve ED systems. The vignettes are not prescriptive.

In this work, we collaborated with the AHS risk management department. The vignettes we created...
are fictitious. They do not represent actual open cases or cases that can be identified as deriving from isolated events. Rather, they are taken from a wide variety of published material as well as from composites of multiple events from many sites and hospitals. We fully embrace what we call “cognitive psychology’s cautionary tale.” By this we mean that hindsight bias and many other human memory frailties limit the process capabilities of single event reenactments.

The step-by-step guide to producing a 5-minute storytelling video includes examples from the video “Morphine Overdose.” The video was created to show the consequences of a number of process failures that led to a morphine overdose. This 5-minute video took 4 hours to produce, with internal staff and leaders, who served as actors, also providing behind-the-scenes support.

**Tool Description**

This tool provides the structure to develop a storytelling video to address safety or performance improvement concerns in the workplace. Steps include

- establishing the aim and locus of interest;
- storyboarding the “story”;
- developing the production plan; and
- developing a diffusion strategy for the video.

The output is a video that tells a compelling story along with a diffusion strategy to support identified safety or performance improvement initiatives.

**Tool Application Settings**

This tool may be used in any setting. It is a valuable adjunct to the work of performance improvement and safety teams. It may also be a major component of process analyses or education and implementation plans to support effective testing or roll-out of new or redesigned processes.

**“Best” Applications**

“Best” applications include critical safety issues, performance improvement efforts requiring true commitment from staff and managers, and complex process flowcharting.
Step Two

Draw a storyboard of the story you would like to tell:
- Sketch out the story in words and phrases.
- Draw pictures/figures.
- Create a video process map walk-through to guide the flow of the video in telling the story.
- Just tell the story—keep it simple! A formal script may not be needed.
A storyboard was crafted using words and phrases. A brief script was created.

Step Three

Decide the cast you will need:
- “Actors” in your organization;
- Senior leaders; and
- Frontline workers (may not be desirable to cast players in their day-to-day work roles!).
The cast included the vice president of quality and outcomes management, line personnel, the ED nurse manager and medical director, and the manager of oncology. These personnel volunteered for the video, and their units had no involvement with the scenario depicted. They were simply willing to participate.

Step Four

- Where will you hold the video shoot?
- When?
The video shoot was held afterhours in the human resources suite (formerly a patient care unit—the environment was easily adapted to “look real” for the clinical scenario).

Step Five

List the props that you will need to make the shoot realistic.
IV (intravenous) bag and pump, patient room, mock chart, pharmacy work area, etc.

Step Six

Dialogue with RM/Legal:
- Use completed outline and subsequent script in your discussion with RM/Legal

Step Seven

Who will shoot the video?
(Anyone experienced with making home videos can do this!)
The hospital audiovisual person shot the video.

Step Eight

Diffusion Strategy Outline
Write out the plan for sharing your story.
The diffusion strategy included a pilot of the video within a safety training program for nurses and pharmacists, small-group sessions on nursing units, and inclusion in mandatory annual medication safety training.

Step Nine

Measurement
- What measures might address the impact of this video?
- Ideas for suggestions from the audience for future videos?
Measures included looking at lessons from the video.

Step Ten

What other storytelling techniques might you use?
- Reenactments?
- Storyboards?
- Newsletters?
We continued to use other storytelling techniques, including safety alerts (one-page key safety points on a specific topic or concern).

* Personal communications between author [J.E.] and Paul B. Batalden, MD, Director, Health Care Improvement Leadership Development, Dartmouth Medical School, Hanover, New Hampshire.
Outputs
Your own storytelling video!

Potential Pitfalls
Thorough exploration and description of the story to be told (Steps One and Two) is a key support for this work. Shortcutting on this part of the process may lead to an ineffective video. Beware of “cognitive psychology’s cautionary tale.”

Results and Lessons to Date
Pre- and posttests of staff focus groups, ratings of helpfulness of the tool (including areas for improvement), and a variety of patient satisfaction and safety metrics that have been in place before and during storytelling work have been used.

Feedback from staff has been overwhelmingly positive concerning
1. usefulness and effectiveness of the process for error analysis;
2. effectiveness of the process to identify how similar errors could be prevented in the future;
3. effectiveness of the video in presenting the errors; and
4. usefulness of the provided tools for error analysis.

Our experience to date suggests that video-based storytelling is a powerful tool. We have learned that involvement of senior leaders in such work adds depth of meaning for line providers. Staff has suggested that we
■ create voice-overs for initial written video scenario set-up points (initial descriptive information preceding actual scenario);
■ edit/improve video regarding clinical details;
■ pay careful attention to the accuracy of props and equipment used;
■ show realistic professional dialogue;
■ realistically demonstrate procedures; and
■ increase the intensity of realistic distractions in the environment (noise, people).

What’s Next
1. We have received support from the Commonwealth Foundation to develop an interactive CD-ROM–based tool in which safety stories will be used as part of a safety education and certification process.
   2. A grant from the Healthcare Foundation of New Jersey is supporting the development of a video in which a series of safety story vignettes will serve as a safety teaching substrate. Safety-associated analytic tools will be illustrated.

Contact Us
Please contact James Espinosa, MD, at Jim010@aol.com

We are especially interested in dialogue with groups working with video-based storytelling and other health care narrative communication tools.

References
6. Personal communications between Jim Espinosa and Paul B. Batalden, MD.