

Effective teamwork & communication in delivering safe care

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Patient Safety Culture

Syndicate Of Private Hospitals

Our Conversation

- * Definition of a group, team, comparison
- * Benefits of team work.
- * What are complementary skills?
- * Characteristics of a team (members selection, roles, training)
- * Why communication is the heart of the matter
- * The limits of human performance
- * Lessons from high reliability
- * Human Factors Skills:
 - * Briefings
 - * Debriefing
 - * Assertion
 - * Situational Awareness
 - * SBAR Technique

Definition of a Team

Group: an assembly of individuals who are together due to common interest, skill or characteristic.

Team: "A team is a small number of people (2-25) with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable."

Katzenbach and Smith (1993).



What are complementary skills?

- These include technical, functional, problem solving, decision-making and interpersonal skills.
- Strategic skills can take a team a long way in relationship building and customer satisfaction.
- And, communication is a primary key to team success.

Working Groups Versus Teams

WORKING GROUP

- Strong, Clearly-focused leader
- Individual responsibility
- Group's purpose is same as the organization's
- Individual work products
- Runs efficient meetings
- Measures performance in terms of larger firm
- Discusses, decides, and delegates

TEAM

- Shared leadership roles
- Individual and shared responsibility
- Specific purpose for which the team is responsible
- Collective work products
- Open-ended meetings for problem-solving
- Performance measured on team products
- Discuss, decide, and work together

John Amatt (1982)



**"Achievement is the constant process
of going 'one step beyond'
your previous experience"**

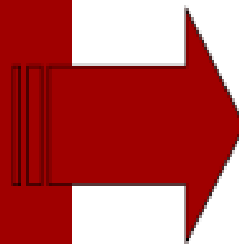
Common Team Responsibilities

■ Quality improvement	100%
■ Cross-training	85%
■ Scheduling (Production)	80%
■ Safety	70%
■ Process improvement	70%
■ Measurement/goal-setting	75%
■ Budget/expense control	50%
■ Selection	55%
■ Coordination with others	50%
■ Customers and suppliers	60%
■ Performance appraisal	50%

Manzand Sims (1993)

Benefits of a Team

- Less stress
- Responsibility is shared
- Sharing of ideas
- More creative ideas
- Less fear of failure
- Sense of accomplishment
- Reward and recognition



- Increase Productivity
- Increased Employee Morale
- Reduced Cost
- Increased Quality
- Decreased Losses
- Increased Profits

When to Form a Team

- A specific, measurable objective that is best achieved through the coordinate efforts of different people with different skills.
- An organizational structure and culture that encourages and provides support for the team concept.
- Adequate time for needed training deliberation, and discussions
- Knowledge and use of various problem-solving and decision making techniques

Team selection criteria

- **Technical abilities:** training, skills, experience
- **Personal attributes:** principles, values, initiatives, organizational identification
- **Interpersonal behaviors:** influence, sensitivity, supporting others, loyalty
- **Communication skills:** dialogue skills, presentation skills, writing skills, reading skills
- **Administrative skills:** planning, organizing, implementing, delegating, evaluating

Different Types of Team

- **Functional Team:** maintaining functional processes involved in delivering a specific output
- **Process Improvement:** improving and/or optimizing processes by which a product or service is delivered
- **New Product Design Team**
- **Project Team:** design and implementation of special projects
- **Problem Solving Team:** analysis and elimination of an undesirable, unpredictable, or unworkable situation

Team Roles

- **Sponsor:** supports, empowers team
- **Leader/coordinator:** organizes team activities
- **Facilitator:** helps team members function as team
- **Evaluator:** looks at the big picture
- **Recorder:** documents teamwork
- **Team worker:** engages in the task completion

Team Competencies

- Team-related Knowledge: Principles and concepts underlying a team's effective performance.
- Team-related skills: learned capacity to interact with other team members
- Team-related attitudes: positive attitudes and mutual trust

Team Training

- Meta-cognitive training: thinking abilities
- Stress exposure training: response to stressors
- Simulator training: Same conditions of work in the classroom (scenarios)
- Team training:
 - Convey information
 - Demonstrate teamwork behaviors
 - Encourage practice
 - Include feedback

Team Training

- Cross-training: Trading roles and tasks among team members
- Team building: role clarification, goal setting, problem solving, and interpersonal relationships.
- Self-correction training.
- Crew Resource Management: Improve management skills and

Why communication?

JCAHO Sentinel Events

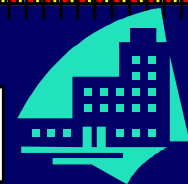
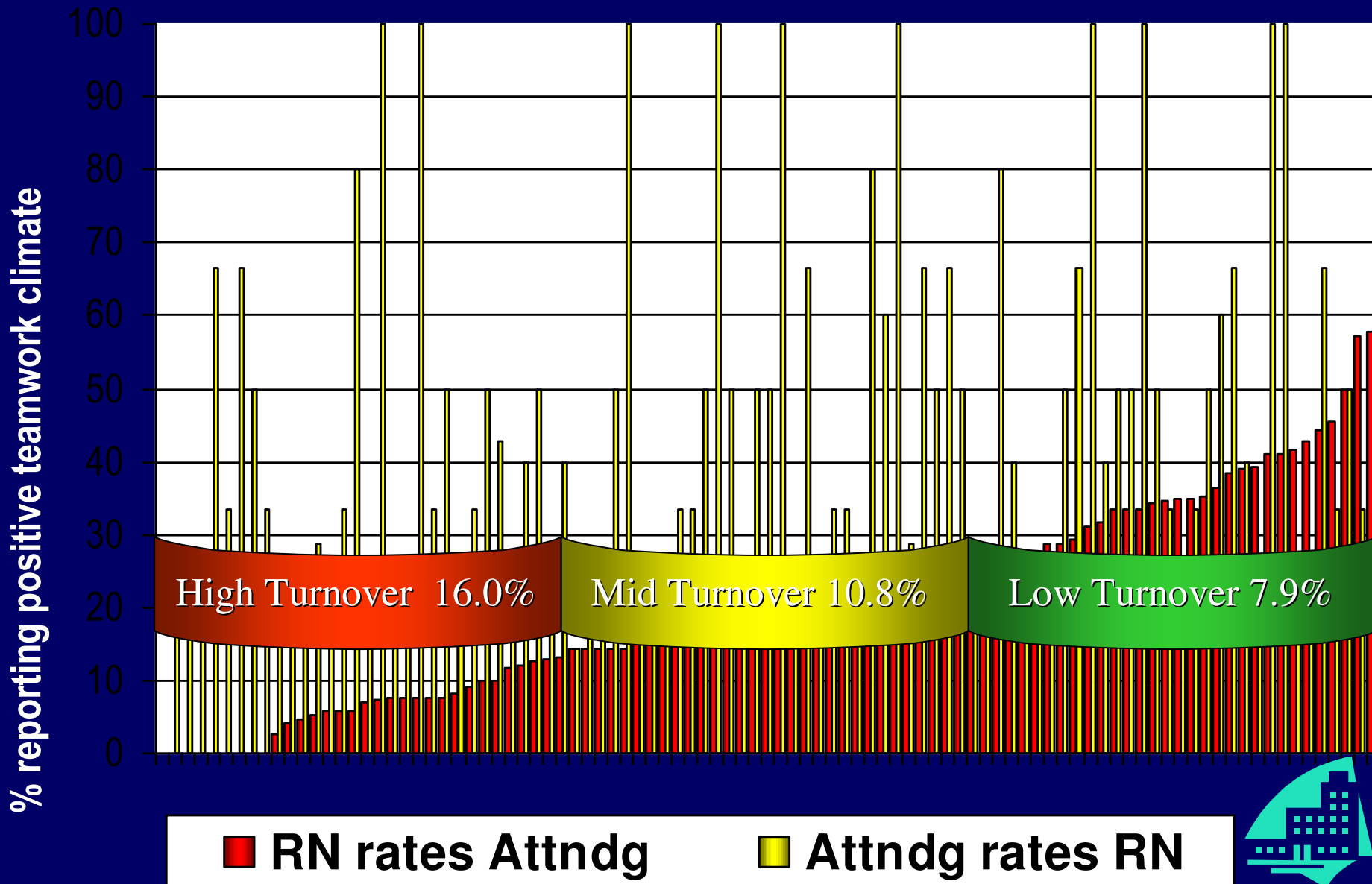
- * Communication breakdowns remain the primary root cause of more than 60% of the 2034 sentinel events analyzed.
- * 75% sentinel events resulted in a patient death.
- * **16.1%** Suicide
- * **12.4%** Operative/post-op complications
- * **11.8%** Wrong-site surgery
- * **11.5%** Medication errors

JCAHO Patient Safety Goals

- * Read-backs on verbal orders
- * Identify patient from 2 sources
- * Verification of correct patient, correct site, correct procedure
- * Briefings before procedures, operations
- * Infusion pumps / monitor alarms



Teamwork Climate & Annual Nurse Turnover



Error is inevitable because of human limitations

- Limited memory capacity (5 pieces of information in short term memory)
- Limited mental processing capacity (Limited ability to multitask – cell phones and driving)
- Negative effects of stress, error rate (Tunnel vision)
- Negative influence of fatigue and other physiological factors
(24 hours of sleep deprivation have performance effects comparable to a blood alcohol content of 0.1%)
- Cultural effects
- Flawed teamwork

Why are healthcare organizations had ineffective communication?

- * Individuals in the medical field are trained to be perfect and to act alone.
- * Medical culture rewards perfection and errors are viewed as personal failures.
- * Fixing the “bad apple” not the system still prevalent.

MD–RN: Different Communication Styles

- * Nurses are trained to be narrative and descriptive
- * Physicians are trained to be problem solvers “ what do you want me to do” – “ just give me the headlines”.
- * Complicating factors: prior relationship between clinicians, gender, culture.
- * Hierarchical system: the clinicians are intimidated to speak up, lack of psychological safety , cultural norms.

Lessons to Learn From Industry ?

Industry Leaders

Toyota, Southwest Airlines, Alcoa

- * **Operationally excellent**
- * **Consistently profitable**
- * **Excellent workforce morale**

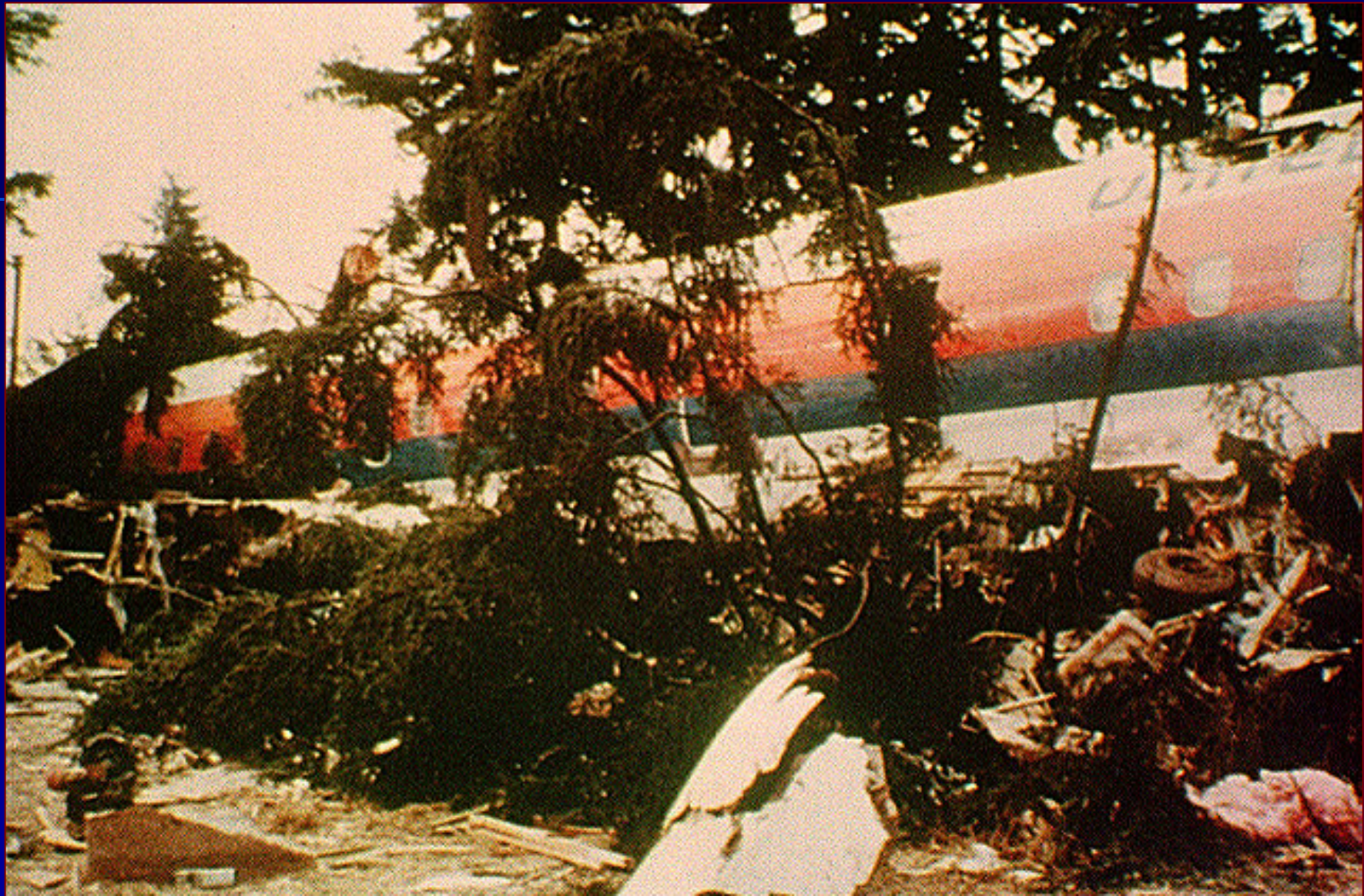
3 Conditions of Habitual Excellence

- * A fundamental, non-negotiable respect for every employee every day by everyone they meet
- * The tools and flexibility to do the job
- * The work is recognized and acknowledged

Paul O'Neill – NPSF 2003

Lessons From the aviation Industry

United Portland – Human Factors Surface



Medicine and aviation

- Safety is primary goal
- Technological innovation
- Multiple sources of threat
- Second guessing after disaster
 - Air crashes
 - Sentinel events
- Teamwork is essential



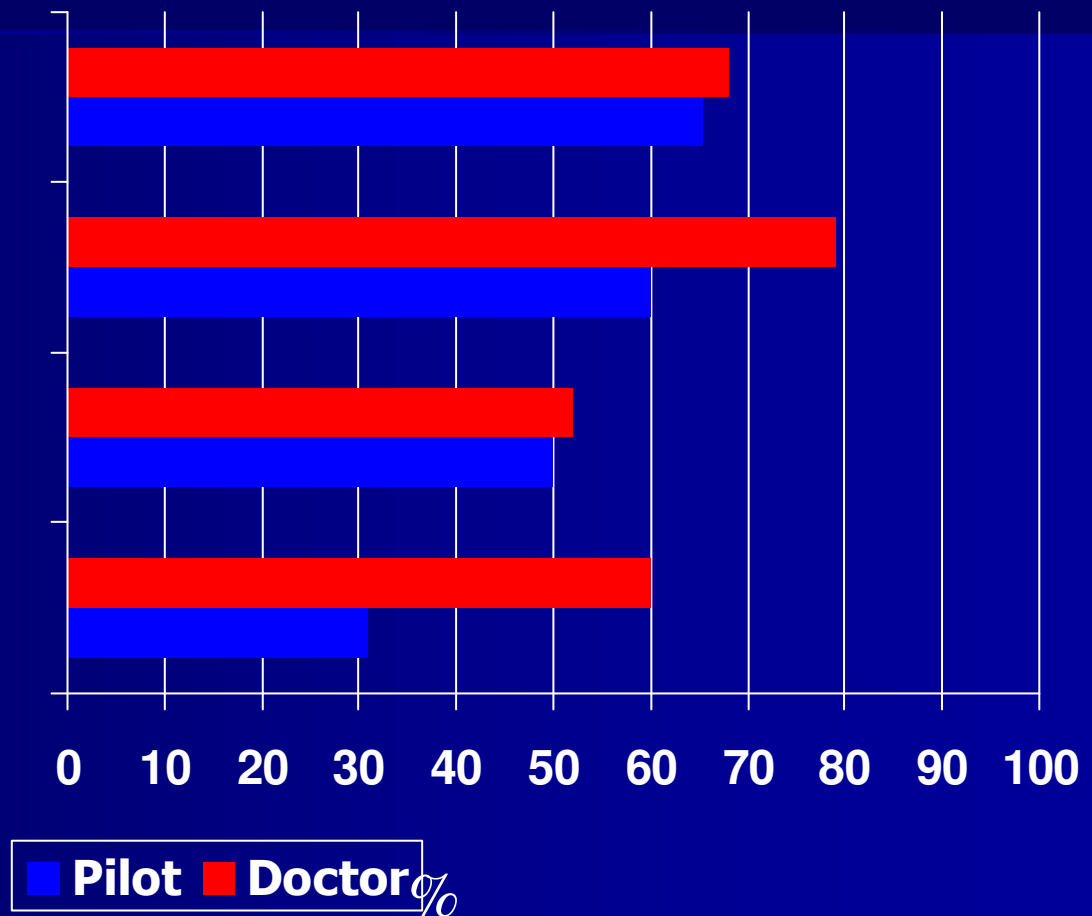
Pilots' and doctors' attitudes

Decision as good in emergencies as normal

Effective pilot/doctor can leave behind personal problems

Performance the same with inexperienced team

Perform effectively when fatigued



In both aviation and
medicine, people must
cope with technology...

Is Technology the
Answer ?



***Not does even newer
technology***



10/22/2000

Changing the culture in aviation

- Human limitation awareness
 - Human factors (CRM) Training
- Fatigue limitations
 - Strictly enforced, FAA mandated duty time limitations
- Failures of teamwork
 - CRM training focused on crew coordination
- Skills maintenance
 - Ongoing training, simulation, FAA and Carrier mandated proficiency checks
- Simplifying complex, error prone systems
 - Automation, checklists, standardization

Crew Resource Management

- * Focus on teamwork, communication, flattening hierarchy, managing error, situational awareness, decision making
- * Non-punitive reporting of near misses, 500,00 reports over 15 years
- * Very open culture with regard to error and safety

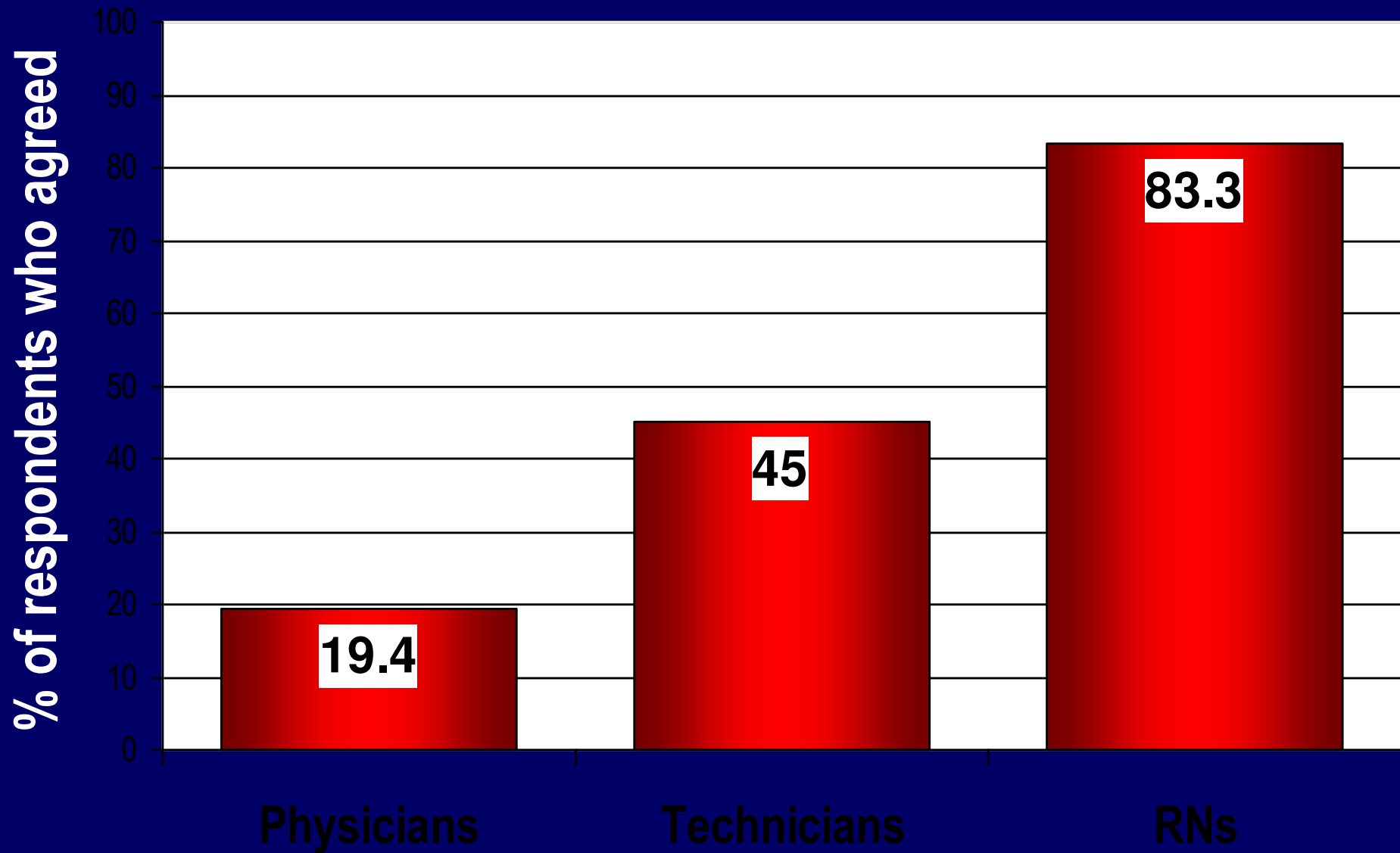
Changing culture in Medicine

Regardless of poor communication, miscommunication or lack of communication, when team is involved in patient care, the members need a systematic approach to facilitate communication.

Why teamwork matters

- Most endeavors in medicine, science, and industry require groups to work together effectively
- Failures of teamwork in complex organizations can have deadly effects
- More than 2/3 of air crashes involve human error, especially failures in teamwork
- Professional training focuses on technical, not interpersonal, skills

"I know the names of all the personnel that I worked with during my last shift"



Communication techniques

- Briefings
- Debriefing
- Appropriate Assertion
- Situational Awareness/red flag
- SBAR process

Briefing

It's a short pause in which the members of the team discuss the specific background of the case, assess threats and risks and offer any other relevant information.

Briefings - Key Elements Checksheet

- * Got the person's attention
- * **Made eye contact**, faced the person
- * Introduced self
- * Used person's name – familiarity is key !
- * Asked knowable information
- * Explicitly asked for input
- * Provided information
- * Talked about next steps
- * Encouraged ongoing monitoring and cross-checking

De-briefing

It's learning from a shared experience, to achieve effective future performance.

De-briefing

- * An opportunity for individual, team and organizational learning
- * The more specific, the better
- * What did we do well?
- * What did we learn?
- * What would we do differently next time ?

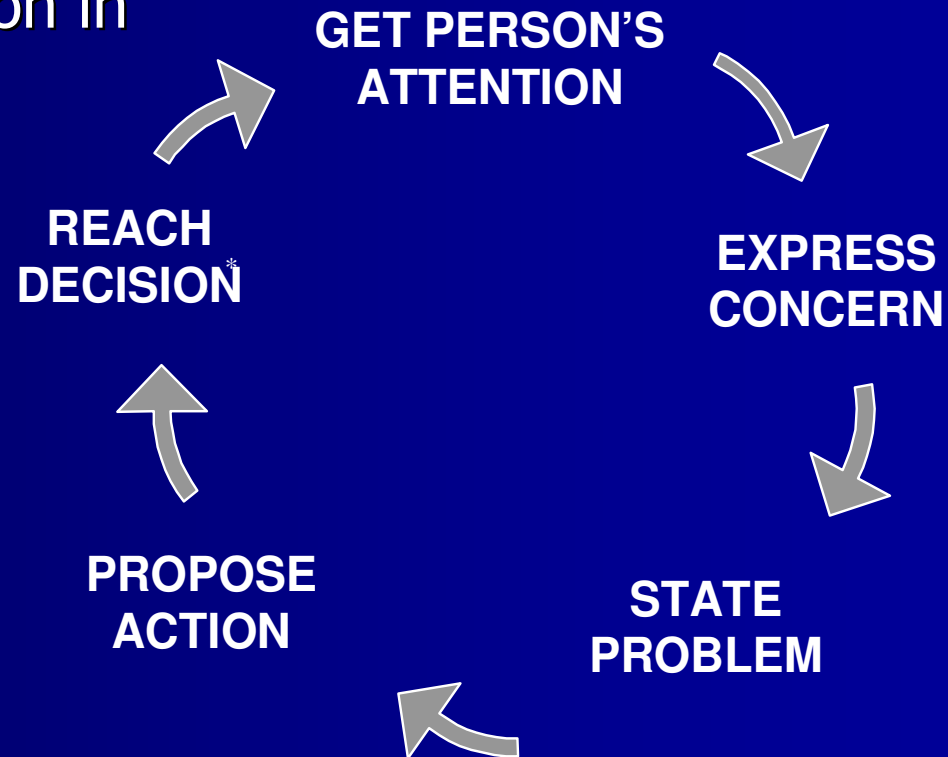
The quality of the debrief
is closely linked to the
quality of the initial
briefing

Assertion - What is it?

“Individuals speak up, and state their information with appropriate persistence until there is a clear resolution.”

Assertion

- Model to guide and improve assertion in the interest of patient safety



Why is Assertion So Hard ?

- * Hierarchy / power distance
- * Lack of common mental model
- * Don't want to look stupid
- * Not sure I'm right
- * Other?

Situational Awareness – Recognizing Adverse Events

Methods to become more aware of the rapidly changing situation and identify

“ Red Flags”

(situation requiring certain actions)

Red Flags – Loss of Situational Awareness

1. Ambiguity
2. Reduced/poor communication
3. Confusion
4. Trying something new under pressure
5. Deviating from established norms
6. Verbal violence
7. Doesn't feel right
8. Fixation
9. Boredom
10. Task saturation
11. Being rushed / behind schedule

S-B-A-R

A tool borrowed from the military that enables individuals in a team to communicate with greater clarity and focus.

S-B-A-R

***S**ituation

***B**ackground

***A**ssessment

***R**ecommendation

Situational Brief Example (1)

- Situation: Dr. Jones, I'm Paul, the respiratory therapist. In my HF training, I was told to get help if I am worried about a patient. There's someone downstairs who's in serious respiratory distress.
- Background: He has severe COPD, has been going downhill, and is now acutely worse..

Situational Brief Example (2)

- Assessment: His breath sounds are way down on the right side ... I think he has a pneumothorax and needs a chest tube pronto before he stops breathing.
- Recommendation: I'd like you to come with me now and see him...I really need your help...this guy's in real trouble.

Guidelines for Communicating with Physicians Using the SBAR Process

1. Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.
 - Direct page (if known)
 - Physician's Call Service
 - During weekdays, the physician's office directly
 - On weekends and after hours during the week, physician's home phone
 - Cell phone

Guidelines for Communicating with Physicians Using the SBAR Process

2. Prior to calling the physician, follow these steps:

- Have I seen and assessed the patient myself before calling?
- Has the situation been discussed with resource nurse or preceptor?
- Review the chart for appropriate physician to call.
- Know the admitting diagnosis and date of admission.
- Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
- Have available the following when speaking with the physician:
 - Patient's chart
 - List of current medications, allergies, IV fluids, and labs
 - Most recent vital signs
 - Reporting lab results: provide the date and time test was done and results of previous tests for comparison
 - Code status

Guidelines for Communicating with Physicians Using the SBAR Process

3. When calling the physician, follow the SBAR process:

(S) Situation: What is the situation you are calling about?

- Identify self, unit, patient, room number.
- Briefly state the problem, what is it, when it happened or started, and how severe.

Guidelines for Communicating with Physicians Using the SBAR Process

(B) Background: Pertinent background information related to the situation could include the following:

- The admitting diagnosis and date of admission
- List of current medications, allergies, IV fluids, and labs
- Most recent vital signs
- Lab results: provide the date and time test was done and results of previous tests for comparison
- Other clinical information
- Code status

Guidelines for Communicating with Physicians Using the SBAR Process

(A) Assessment: What is the nurse's assessment of the situation?

(R) Recommendation: What is the nurse's recommendation or what does he/she want?

Examples:

- Notification that patient has been admitted
- Patient needs to be seen now
- Order change

Guidelines for Communicating with Physicians Using the SBAR Process

- 4. Document the change in the patient's condition and physician notification.

High Reliability Units*

- Safety first is the hallmark of the culture
- Team contribution is valued
- Communication is structured and rewarded
- MD comes when called by RN
- Evidence-based protocols are utilized
- Emergencies are rehearsed

* Knox, Simpson, JHRM, Spring 99