How to Turn High Performing Individuals Into a High Performing Team

"Greater experience does not necessarily lead to expertise. One may simply make the same mistakes with greater and greater confidence."
- Cochrane Report

The Beginning...

- IOM Report: 1999
  To Err is Human: Building a Safer Healthcare System

Development of a “Systems” Focus

- Redundancy
  - Double checks, medication reconciliation, read backs, sign your site, time outs, etc...
- Simplification and standardization
  - No high risk abbreviations, adopt protocols and pathways (e.g. vent/line bundles)
- IT implementation
- Reporting systems (local and national)

An error waiting to happen...

Standardization

Limits of Systems Only Safety

- Inflexible and Boring
  - Stifles innovation and enthusiasm
- Tension between “getting the work done” and new ‘systems or rules’ creating workarounds
- Limited reach – healthcare is too messy to completely standardize
Safety culture is the product of individual and group values, attitudes, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of an organization’s health and safety programs. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures.”

Advisory Committee on the Safety of Nuclear Installations (1993)

What is Culture?

“...the way we do things around here.”

When fatal medical blunders occur the tense first question has been, “Who did it”. Now with the help of a discipline called human factors analysis hospitals are learning to ask...

Safety Culture Across 100 Different Organizations

Safety Culture Across Clinical Areas in the Same Organization

Culture is Local...
Death rates from complications vary significantly from hospital to hospital.

Why?

Because opportunities to identify complications, to mobilize help and resources and to intervene in a timely fashion are commonly lost… Usually because of communication and teamwork failures.

HIGH RELIABILITY

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The Ability to perform technologically sophisticated tasks over long periods of time without error.

Can We Make Healthcare Safer?

“In virtually every case where patients are harmed, somebody knows there’s a problem but they can’t get the rest of the team focused on fixing it.”

Michael Leonard, MD

Sentinel Events

3 Errors are Common

Failure to: Observe the patient with the appropriate level of surveillance.
Failure to: To recognize complications

Sentinel Events
3 Errors are Common

Failure to: Respond to recognized complications in an appropriate time-frame

Skills
Thinking
Communication

Thinking...
A Consistent Approach
In complex non-medical environments the importance of using a consistent mental model to train staff to become effective decision-makers, particularly in emergencies, has long been recognized.

Thinking...
Creates Consistent Expectations
Training programs in a variety of domains have shown that repeated and consistent experience in an environment, allows operators to develop more accurate expectations about future events.

The New Yorker
Medical Dispatch
NO MISTAKE

The future of medical care; Machines that act like doctors and doctors that act like machines.

Atwal Gwande
The education systems for doctors and nurses emphasizes teaching clinical skills to individuals.

Superb individual clinical skills do not guarantee the kind of effective team performance in healthcare delivery required to avoid making catastrophic errors.

When errors occur, they generally arise from a combination of system and teamwork failures.

We train, learn, and work in silos…

Adapted from TOPS PROJECT UCSF School of Nursing
Team of Experts Into an Expert Team

November 1999: IOM Report To Err is Human: Do No Harm Prevent Harm

To paraphrase William Richardson, Chairman IOM Committee: Our health care services promise to our patients to first “Do No Harm.” The recommendations we submit to you during the course of this conference are intended to encourage you to take the actions necessary to improve safety.

We must have a health care system that makes it easy to do things right and hard to do them wrong.”

How Do We Make Healthcare Safer? Where Culture Eats Strategy…

Niraj Sehgal, MD, MPH
Assistant Professor of Medicine, Hospitalist Group
University of California, San Francisco

“The Right Kidney”

We Tell Stories

A 56 yo white female is taken to the OR and prepared for kidney transplant surgery. The attending surgeon sends a surgical resident to retrieve a “Right kidney” from the organ storage room shelf. Neither the resident nor the nurse he finds to open the room have ever entered the organ storage room before. The resident scans the shelf with organs and points to a box labeled “right kidney”. “That’s it…the “right one right there.”

The nurse retrieves the box and heads to the OR… She hands the organ to the circulating nurse she sees in the hallway outside the OR.

The patient is already intubated. The kidney is placed in a bowl, and brought onto the sterile field.

The surgeon arrives in the room and prepares to begin the surgery…then suddenly stops.
“Right Kidney”

Having worked on the kidney the day before in preparation for the surgery, he notices something is wrong. This isn’t the right kidney he states emphatically. The resident says but it is the “right kidney”. The attending replies... It may be a “right kidney” he says but it isn’t the right kidney for this patient.

A week later there was a death at Duke University Medical Center

17 year Jessica Santillan died after receiving a heart–lung transplant from an incompatible donor. Her blood type was O, the donor’s was A, and the mismatch was not recognized until after the operation was over.

How good are we at communicating and teamwork?

Root Causes of Sentinel Events
(All categories; 1995-2004)

Root Causes of Wrong Site Surgery

Root Causes of Medication Errors
**Perceptions of Teamwork “High”**

- Attending Surgeons
- Anesthesiologists
- Surgical Nurses
- Anesthesia Nurses
- Anesthesia Residents

Sexton, British Medical Journal, 2000

**Decisions of the “leader” should not be questioned**

Sexton, British Medical Journal, 2000

**Quality of Teamwork across 25 organizations: Differences between Physicians & Nurses**

- Scale (1=very low to 5=very high)

**Communication Barriers**

What Are They?

**Silence Kills**

American Association of Critical Care Nurses sponsored a study with Vital Smarts
Presented at a press conference in January 2005 with the release of AACN’s Standards for a Healthy Work Environment

- 53% Nurses concerned about a peer’s competence
- Only 12% have shared their concerns with this peer
- 68% physicians concerned about another physicians’ competence
- <1% have shared their concerns with this peer
Silence Kills

- 81% physicians concerned about a nurses competence
- Only 8% have shared their concerns with this peer
- 34% nurses concerned about a physicians competence
- <1% have shared their concerns with this peer

Silence Kills

Silence contributes to patient harm
Nurses report several reasons for not speaking up:

- I don’t want to appear to be stupid
- What if I’m wrong?

Silence Kills Results

- Good news: 10% of nurses and physicians in the survey did speak up
- These confident colleagues reported a higher satisfaction with their work setting and less intention to leave
- What can each of us do to create the circumstances where the other 90% can speak up?

Available at: http://www.vitalsmarts.com

How Do We Do It?

- Focus on Culture & Communication Skills
- Develop Team Behaviors
- Create the right motivators
  ...things will get done quicker
  .....more efficiently
  .....workflow will be managed better
  ......PATIENTS will be cared for safer.

TOPS PROJECT UCSD School of Nursing
3 Key Principles

- Effective communication can reduce the likelihood of errors and patient harm
- Teamwork reduces the likelihood that when errors occur they will result in patient harm
- Care must be patient centric to be safe and reliable.

Effective Information

- How the information is given
- Where emphasis is placed
- Impacts how fast the information you communicate is acted upon.

Communication Tools and Strategies

**SBAR**
- Advocacy
- CUS Words
- Inquiry

Structured Communication

What Is SBAR?

Framework for communicating critical information about a patient's condition. That requires a clinician's immediate attention and action.
**SBAR** is used for a Situational Briefing

**Situation**
Get the persons attention quickly. Identify the patient and yourself and your reason for calling. (5-10 seconds)

**Background**
Give pertinent background information

**Assessment**
Tell them what you think is going on

**Recommendation**
What you want them to do, why, when?

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Before you send a text message or pick up the phone be certain about what your RECOMMENDATION is:

1. Know what you want them to do.
2. Why you want them to do it, and
3. A time frame within which your request needs to be accomplished.

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I'm Paul the nurse from 7 south. Mrs. Smith in 742 is in respiratory distress. She has severe COPD, has been doing poorly all day, and is now worse. Her breath sounds are diminished. She's not moving much air. I think she needs a treatment before she stops breathing.

I'd like you to come and evaluate her immediately.

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**Building A Highly Reliable Team**
**Healthcare Team Behaviors**

- Skills
- Leadership
- Communication
- Inquiry
- Advocacy (Assertion)
- Workload management
- Resource Management
- Situational Awareness

TOPS PROJECT UCSF School of Nursing
How to Use Assertion to Effectively Advocate for the Patient.

How do you do it?

Get the Person’s Attention

Express Concern

State the Problem

Propose an Action

Reach a Decision

“I Am Concerned”

Have You Cussed Today

Critical Language understood by all to mean “Stop and Listen to Me – we have a potential problem”

- United Airlines CUS program
- “I’m concerned”...
- “I’m uncomfortable”...
- “This is unsafe”...
- Allina Hospitals
- “I need some clarity”
- UCSF Patient Safety Project
- “In the interest of the patient”

I’m Paul the nurse from 7 south. Mrs. Smith in 742 is in respiratory. I’m really concerned about her!

She has severe COPD, has been doing poorly all day, and is now worse. Her breath sounds are diminished. She’s not moving much air. I think she needs a treatment before she stops breathing.

I’m uncomfortable about her condition. I’d like you to come and evaluate her immediately.

WhenAssertionFails

When things go wrong we often find...

Concern is usually expressed
Problem is stated, often not clearly
Mutual Decision is not reached and/or the decision is not consistent with the patients condition.
Proposed action doesn’t happen or is not accomplished in a time frame in keeping with the urgency of the situation.

I’m uncomfortable about her condition. I’d like you to come and evaluate her immediately.

MD: We’re really slammed. We can’t come up right now.

RN: I appreciate you’re busy. Who else can we call?

MD: There really isn’t anybody else available right now. Everyone is as busy as we are.

RN: I don’t think it’s safe for her to not be seen immediately by a physician.

RN: Why don’t we call the Rapid Response Team?
The healthcare team member who initiates a call/conversation will be prepared to communicate all pertinent information clearly and concisely.

The recipient of the information will actively seek clarification if they are unclear about the information given, or the reason the call was initiated.

Effective Communication Is A Two Way Street

**SBAR**
The healthcare team member who initiates a call/conversation will be prepared to communicate all pertinent information clearly and concisely.

**INQUIRY**
The recipient of the information will actively seek clarification if they are unclear about the information given, or the reason the call was initiated.

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**Critical Conversations**

**Admission**
- Things will get done quicker
- More efficiently
- Workflow will be managed better
- **PATIENTS WILL BE CARED FOR SAFELY**

**Change in Patient Condition**
- Worsening on the floor, transfer to or from higher level of care, coming out of OR, etc...

**Discharge**

**Triad for Optimal Patient Safety (TOPS)**

- School of Nursing
- School of Medicine
- School of Pharmacy

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RT this is Mike the triage RN on the OB floor. We have a pregnant patient in respiratory distress. She's 39 weeks. History of asthma. Sats 90%, wheezing and retracting.

She's in respiratory distress. We need you to come stat.

A Successful SBAR is

- **Short**
- **Quick**
- **To the point**

**RN-MD Critical Conversations**

- **Change in patient condition**
  - Worsening on the floor, transfer to or from higher level of care, coming out of OR, etc...

- **Discharge**
**Phase I: 4hr TOPS Training**

- Curriculum Working Group (TOPS, Mach One, etc...)
  - Needs Assessments to guide content development
  - "Train the trainers" session for all three sites
- Training Agenda for 4 hours:
  - Laying the Foundation
  - First, Do No Harm Video Presentation & Discussion
  - Healthcare Team Behaviors & Communication Skills
  - Small-group facilitated ‘scenarios’ to teach and practice SBAR, CUS words, team behaviors...
- Outcome: more than 325 "TOPS trained"

**Phase II: TrUST**

- **What do we do?**
  - Capturing of ‘stories’ and safety issues
  - Tell a TrUST Member
  - TRUST Coupon
  - TRUST Meetings (Discuss issues)
  - TRUST facilitates bringing issue to appropriate group
  - TRUST feeds issue into an educational activity conference
  - TRUST takes action with a plan for issue resolution
- *Educational Activity*:
  - Debrief an event
  - Organize a project
  - Devise a solution
  - *Med Ctr Committee*

**Phase II: Educational Activities**

- Patient Safety Conferences
  - Large-group and multidisciplinary audience
  - Case-based “M & M”-type presentation
  - Build on principles from initial 4hr Training
- Small-group Skills Sessions
  - “Scenario or case” driven
  - Practice skills and engage participants
  - Travel to discipline-specific venues
  - Leverage existing or planned educational activities

**Phase III: Patient Engagement**

- Tell Us Cards
  - **TELL US A GOAL THAT WILL IMPROVE YOUR CARE**
  - EXAMPLES OF YOUR GOAL MIGHT BE:
    - To talk with your doctor
    - To find out the result of a test
    - To discuss a medication
    - To talk about an unexpected symptom
Summary

- *Teamwork Training* is only a part of a program to address safety culture
- “Local Champions” must drive the change
- Educational activities need to be coupled with operational initiatives
- Culture eats strategy...

Safety Culture Across 100 Different Organizations

![Safety Culture Across 100 Different Organizations](Sexton.png)

Job Satisfaction Across Orgs

![Job Satisfaction Across Orgs](K P ---.png)

Clear Operating Style

1. Professional communication will be maintained at all times.

2. The healthcare team member who initiates a call/page will be prepared to communicate all pertinent information clearly and concisely.
3. The recipient of the information will actively seek clarification and data from the team member(s) and other resources if they are unclear about the information given, or the reason the call was initiated.

4. If an action/intervention is required, a mutually agreeable time frame within which the intervention will be accomplished will be identified.

5. Before the communication is terminated, the providers will re-state what they have mutually agreed to do, and the time frame with in which the action will be accomplished.

What Lessons Can We Learn From Excellence in Industry?

Truly exceptional organizations – Southwest Airlines, Toyota, Alcoa all have the same properties:
- Everyone is treated with respect every day
- The work is recognized and acknowledged
- Employees have the tools and flexibility to do the job

There is a direct link between work environment and patient safety

If you are not addressing your work environment, you are not addressing patient safety.

Communication is a major component of the work environment.

Three Fundamental Tensions

- How to promote no blame culture for innocent slips or mistakes while holding persistent rule violators or incompetent providers accountable
- How to hold institutions accountable for allowing unsafe conditions without hammering them in the newspaper or the courts when they acknowledge their flaws
- How do we work to undo generations of tradition and practice that clearly don’t fit the current needs of our healthcare system
While some of us may be in private practice, none of us practice privately.

“Remember, you fly an airplane with your head, not your hands. Never let an airplane take you somewhere your brain didn’t get to five minutes earlier.”

Mental Simulation
Thinking Ahead