

# Effective Teamwork & Communication: The Path to Safe & Reliable Care

Michael Leonard, MD

New Mexico Hospital Association

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**LEADERSHIP**

**PATIENTS**

**HUMAN FACTORS**

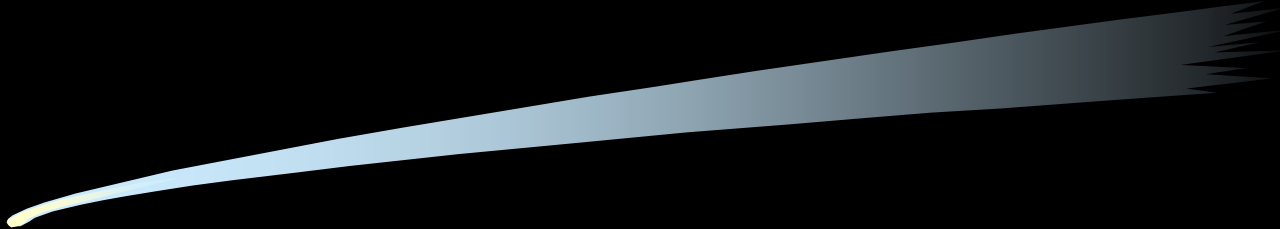
**RELIABILITY**



# A System Error Gets Personal

# A Simple Arthroscopy

- \* 45 y/o healthy woman, wanted to ski more
- \* Friday afternoon, last case for Chief of Orthopedics
- \* OR running late, 26 rooms
- \* Two nurses moved to ortho to do “no brainer” case
- \* They have never worked in orthopedics

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- \* Repeatedly interrupted
  - \* Team disrupted by anesthesiologist wanting EKG recording paper
  - \* Working with people they didn't know
  - \* Loud music in the room
  - \* ..... with epi



# Fair and Just Culture

- \* What are the rules?
- \* Does everyone know them?
- \* How do we differentiate an individual with a problem from a good person set up to fail in an unsafe system?
- \* The critical importance of having one set of rules

# Drawing the Bright Line

Malicious

Substance Use

Violation of Rules

Repeat Events = **remediate**

Competency = Substitution Test

**Safe Harbor –  
Systems  
Approach**

Reason, J.



# Effective Teamwork and Communication



# Why Communication ?

- \* The overwhelming majority of untoward events involve communication failure
- \* Wrong site surgery - somebody knows there's a problem but can't get everyone in the same movie
- \* The clinical environment has evolved beyond the limitations of individual human performance

# Effective Communication Requires:

- \* Structured communication – SBAR
- \* Assertion/ Critical Language – key words, the ability to speak up and stop the show
- \* Psychological safety – an environment of respect – effective leadership

# SBAR – Situational Briefing Model

- \* Used in the nuclear submarine service for concise and accurate communication
  - **S** – situation – what’s the situation?
  - **B** – background – how did we get here ? the context
  - **A** – assessment – what do I think the problem is?
  - **R** – recommendation – what are we going to do to fix it?



# Assertion / Critical Language

- \* A word that is understood by all to mean “let’s take a minute and make sure we’re on the same page”
- \* A great example is “ I need a little clarity” from Allina Hospitals
- \* We need critical language because often people are hesitant to speak up

# Psychological Safety

- \* It is critically important that people feel safe speaking up. Psychological safety has a profound impact on team performance.
- Does it feel safe to speak up ?
- Will I be treated with respect?
- Will they help fix my problem?
- \* IF you don't get the right answers, then it gets risky



# The Need for Teamwork

- \* Clinical medicine is an extremely complex environment with:
  - Surprises
  - Uncertainty
  - Incomplete information
  - Interruptions and multitasking
  - What are the surprises in your world?



# Inherent Human Limitations

- \* Limited memory capacity – 5-7 pieces of information in short term memory
- \* Negative effects of stress – error rates
  - \* Tunnel vision
- \* Negative influence of fatigue and other physiological factors
- \* Limited ability to multitask – cell phones and driving

# Where do Things Fall Through the Cracks ?

- \* Systems – information, tests, diagnoses
- \* Communication – especially hand-offs
- \* Failure of planning
- \* Failure of recognition
- \* Failure to rescue

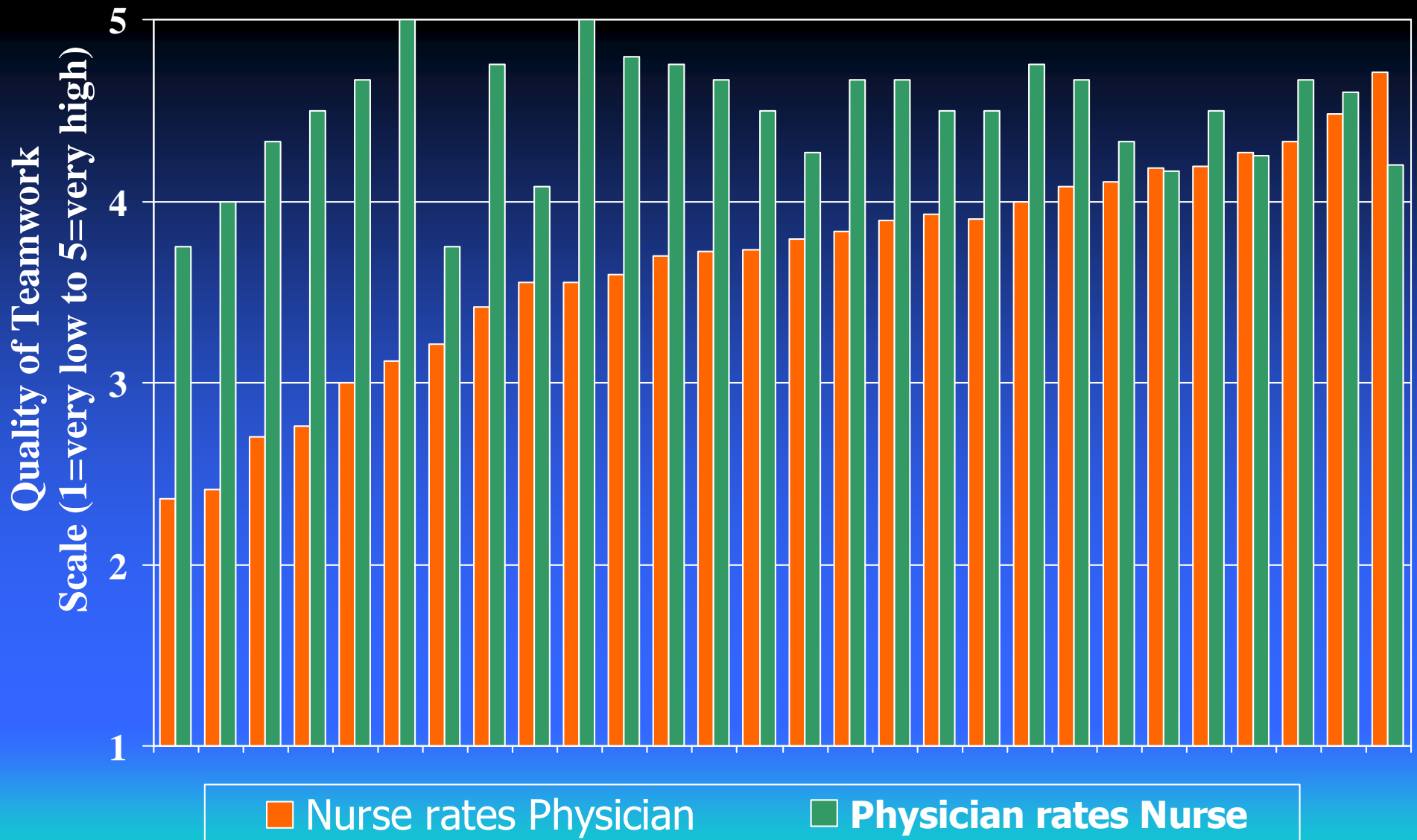
# Verbal Read Backs

- Crash C-Section – unit secretary plays a critical role in coordinating communication
- Verbal read-back between clinician and unit secretary
- “Susie, we have fetal distress in 403, we need peds, anesthesia and the charge nurse, we need to get this baby out in 10 minutes at 9:25”
- “Please read back what I said”

# 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: gender, national culture, power distance, prior relationship
- \* Perceptions of teamwork depend on your point of view

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



# Structuring the Nursing Work

- Big picture or task performance?
- Tucker & Spear: med-surg observation, at least 100 discrete tasks per 8 hour shift:
  - Average 3 minutes / task
  - No ability to sequence – juggling, prioritizing tasks
  - Formally interrupted at least once / hour

Tucker AL, Spear SJ, HSR,  
June 2006

# Ask Your Nurses this Question:

- How many of you in the recent past have NOT had the experience of standing at a patient's bedside, seeing something concerning and thinking:
  - Is it important?
  - Should I call?
  - Do they want to know?
  - What kind of reception am I going to get?

# Reliable Processes of Care

- \* How do we make it easy to do the right thing?
- \* How do we measure and feedback information?
- \* How do we learn and improve?
- \* What are the tools – Toyota Lean, Six Sigma, etc.



# Keeping Score

- \* Cultural Surveys
- \* Observation and feedback
- \* Clinical outcomes and process metrics



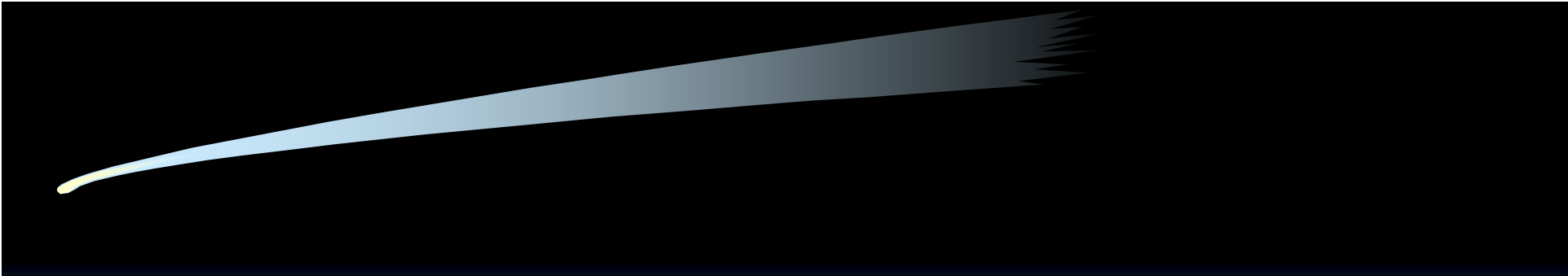
# Patients & Families in the Game

# What Does it Look Like to the Patient ?

- \* Do they understand?
- \* Do we care?
- \* Do we know what we are doing?
- \* Do we take the time for relationships?

# Health Literacy

- \* Do you have a systematic approach to detecting and managing this problem?
- \* It's a huge problem – silent, pervasive, huge ramifications
- \* Rx – Ask Me Three, Teach Back



Is Technology the  
Answer ?



# HUMAN FACTORS

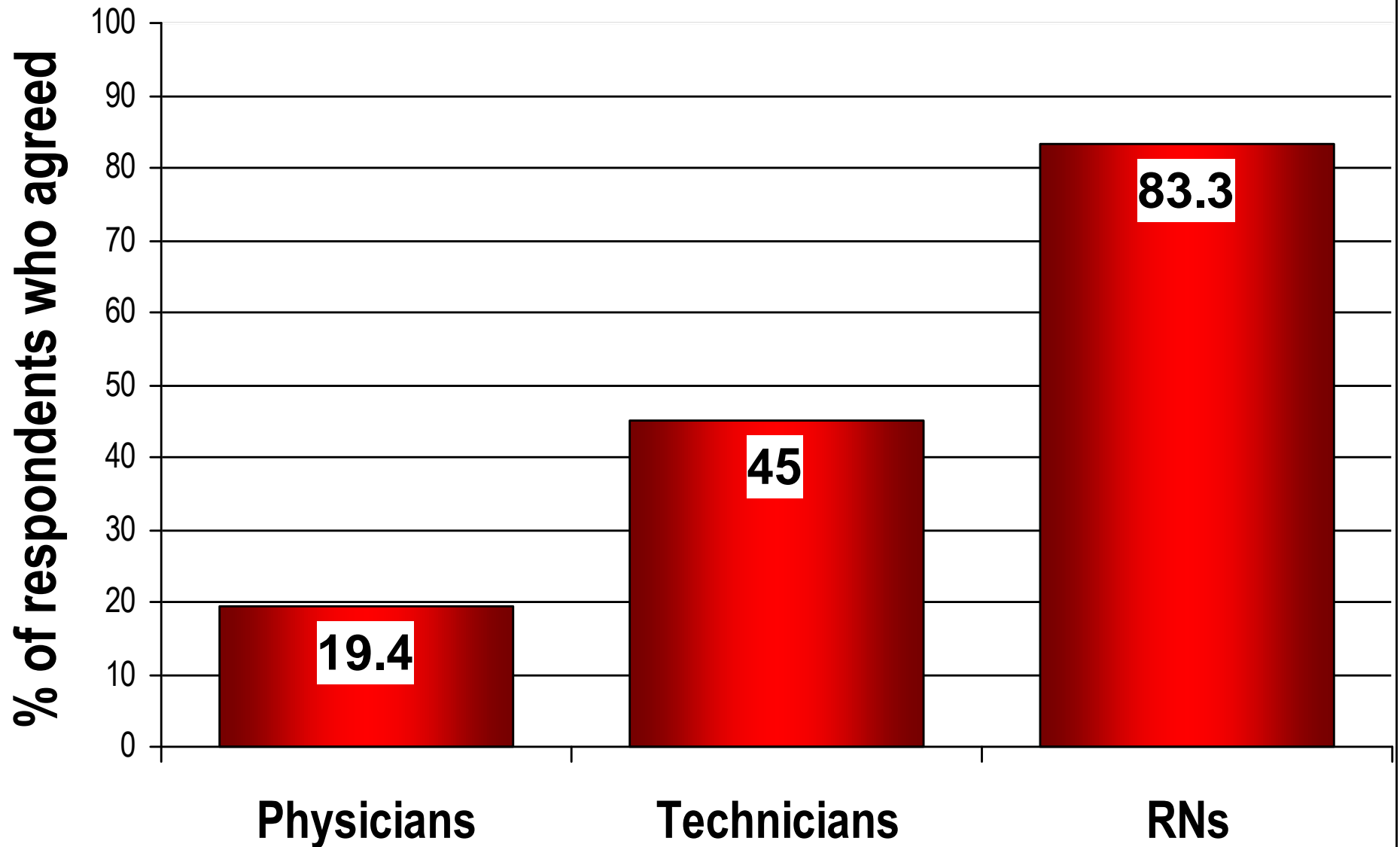
- \* Briefings
- \* Appropriate Assertion
- \* Situational Awareness
- \* Debriefing
- \* Common Mental model

# Setting the Stage

\* Vascular surgeon doing new, complicated procedure – endovascular aortic stent - in CV lab:

“I don’t have any pride invested here. I just want to get this right, so if you think of anything helpful or see me doing anything wrong, please let me know.”

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



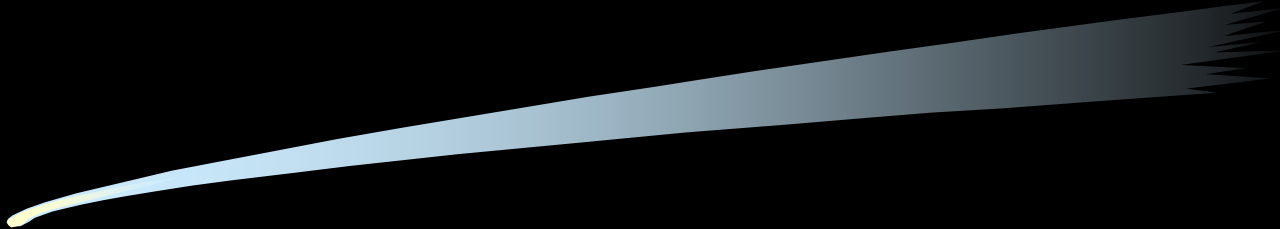
# Situational Briefing Model

S-B-A-R

- \* Situation
- \* Background
- \* Assessment
- \* Recommendation

# SBAR Example

- Situation: We have a 68 year-old man with metastatic lung cancer and COPD sent for a study – he's so short of breath that he can't tolerate the study
- Background: He's more acutely short of breath, and the pulmonary docs want to know if there's another problem. He's O2 dependent, breathing 40 times a minute, his O2 sat is 83%.

- 
- A decorative brushstroke in shades of blue and white, starting from the left and tapering towards the right, is positioned at the top of the slide.
- Assessment: This patient is too unstable for the study
  - Recommendation: We need the pulmonary docs to stabilize him before we can do this or someone will need to be her with him. How can we fix this?

# SBAR Report to a Physician



## **BEFORE CALLING THE PHYSICIAN:**

1. Assess the patient
2. Review the chart for the appropriate physician to call
3. Know the admitting diagnosis
4. Read the most recent physician and nursing notes
5. Have the chart in hand and be ready to report allergies, medications, IV fluids, lab and test results.
6. Every SBAR report is different. Focus on the problem. Be concise. Not everything in the outline below needs to be reported -- just what is needed for the situation.

# S

### **Situation**

- State your name and unit
- I am calling about: Patient Name & Room Number
- The problem I am calling about is: \_\_\_\_\_
- If this is a serious problem say what the code status is.

# B

### **Background**

- Briefly state why the patient is in the hospital give a synopsis of the treatment to date.
- Give the vital signs, oximetry, and how much oxygen is being given.
- Relate the complaint given by the patient and the pain level.
- Relate the physical assessment pertinent to the problem especially any changes.
- Pay special attention to mental status, skin temperature and emotional state of the patient.

# A

### **Assessment**

- Give your conclusions about the present situation. Words like "might be" or "could be" are helpful. A diagnosis is not necessary.
- If the situation is unclear at least try to indicate what body system might be involved.
- State how severe the problem seems to be.
- If appropriate, state the problem could be life threatening.

# R

### **Recommendation**

- Say what you think would be helpful or needs to be done, which might include:
  - medicines,  tests,  x-rays,  ECG,  D-dimer,  BN peptide,  CT for PE,
  - transfer to critical care,  physician evaluation, or  consultant evaluation.
- Make sure to clarify how often to do vital signs and under what circumstances to call back.



**DOCUMENT THE CHANGE IN CONDITION & THE PHYSICIAN NOTIFICATION**

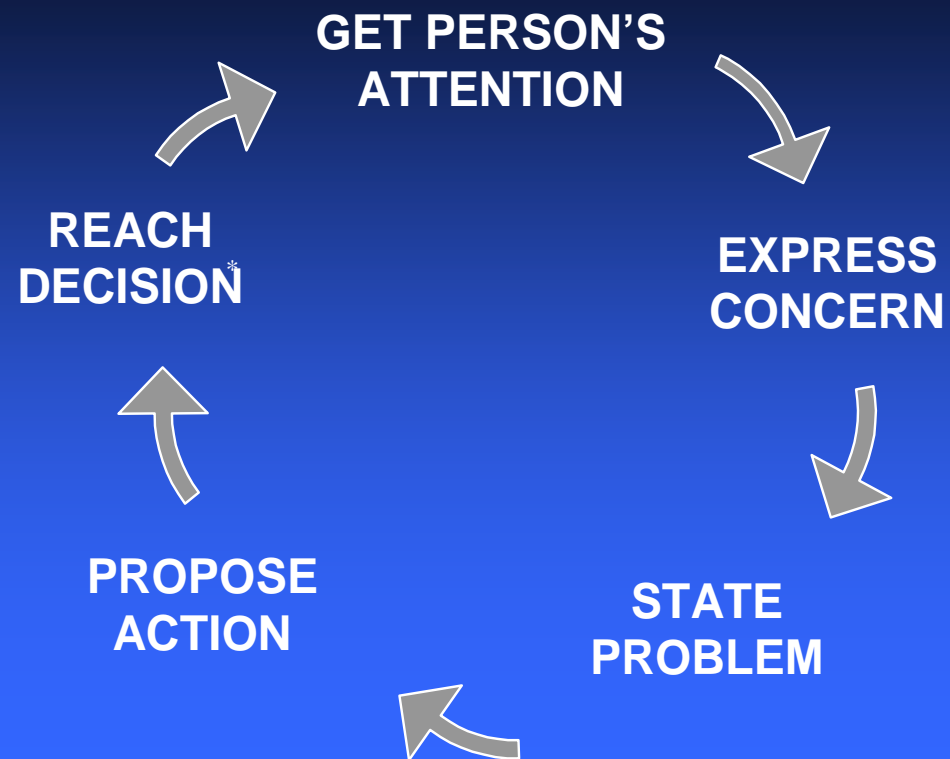


## **Assertion - What is it?**

“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



# Expert Decision Making

- \* Expert – pattern matching against large mental library, quick, accurate if confirm correct answer
- \* Novice – library is empty – slow, error prone process
- \* Certain Diagnoses are Favored- Frequent, Recent, Serious
- \* Heuristics

# Critical Language

- Key phrases 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... I’m scared”
- Allina – “ I need some clarity”

# Why is Assertion So Hard ?

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

# How do Experts and Novices Make Decisions?

- \* Experts pattern match against a large mental library of past experience. It's very quick and quite accurate if they continue to seek confirming evidence
- \* Novices can't do this, their library is empty - they haven't seen it before. They use a slow, error prone process
- \* Experts need to teach the patterns to novices, even if the answers appear overly obvious – that's how we help them become expert

# 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 / Boredom / Task saturation
9. Being rushed / behind schedule

# Debriefing

- \* 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 ?
- \* Take a minute or two to learn when it's fresh in everyone's head



# Effective Debriefing

- \* Be crisp and to the point
- \* Do it when the experience is fresh
- \* Everyone get a chance to speak
- \* Start with the junior folks – otherwise they can be overshadowed by the veterans
- \* Be specific
- \* Avoid judgment – this has to be a positive learning experience

# The Difficult Conversation – How to Achieve Agreement

- \* Focus on the common goal – high quality, safe care
- \* 3<sup>rd</sup> person – depersonalize the conversation – it's not about you and me
- \* Avoid judgment; who's right, who's wrong is a loser
- \* What needs to happen for us to do the right thing here?

# Elements of Safety and Organizational Excellence

- \* Leadership – modeling the behaviors – driving the culture
- \* Culture – tools and behaviors for effective teamwork and communication
- \* Systems – reliable processes of care
- \* Metrics – cultural surveys, observation, process measures, clinical outcomes.