Teaming for Success in Patient Safety

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The University of Kansas Hospital

- Founded in 1906, became a public authority in 1998 and a clinically integrated health system in 2016
- Tertiary and quaternary hospital; the teaching hospital for the State of Kansas
- Licensed for 910 beds, staffed to support 847 beds and 24 FT nursery beds
- Over 80 facilities providing inpatient and outpatient care
- Service lines include cardiology, cancer, neurosciences, trauma, critical care, organ transplantation, and burn.

The University of Kansas Hospital

- FY17 Volume:
  - 54,659 Discharges (IP, OP & Extended Care/Procedure)
  - 822,075 Outpatient Encounters
  - 53,534 Emergency Department Visits
  - 12,630 Inpatient Surgical Discharges
  - 55,705 Outpatient Surgeries

- Over 10,500 employees

- Accreditations include TJC, CAP, Level 1 ACS Trauma, Burn Center, Advanced Comprehensive Stroke Center, NCI, ACS Commission on Cancer, Blood Bank, Radiology, FACT and Chest Pain Center
Objectives

- Describe the components of a high reliability organization
- Identify methods to improve safety in a highly complex system
- Explain the importance of teamwork and teaming as necessary components to providing the safest patient care possible.
Complexity of healthcare

*Medicine used to be simple, ineffective and relatively safe*

*Now it is complex, effective and potentially dangerous*

Sir Cyril Chantler
By Show of Hands

- Who has ever been involved in a patient safety event?
- Who has been involved in a patient safety event where someone was seriously harmed?
- Who has been involved in a patient safety event where someone died?

Safety Culture maturity model

Levels of maturity with respect to a safety culture

- Where are you now?
- Where do you want to go?
- How do you get there?
Its so hard!

Reliable Care – Delivering what the patient needs when they need it each and every time

Is healthcare highly reliable?
High Reliability Organizations

1. Sensitivity to operations
   - Constant awareness to and prevention of risks

2. Reluctance to simplify
   - Understand the true reasons patients are placed at risk
   - Why, Why, Why, and Why

3. Preoccupation with failure
   - Focus on near misses as opportunities to improve

4. Deference to expertise
   - Frontline experts

5. Resilience
   - Understand and know how to respond when failures occur

1. Sensitivity to operations
   - Build a clear picture of the situation
   - Be familiar with operations beyond one's own job
   - Seek first to understand
   - Speak up
   - Encourage others to speak up and ask questions
   - Check for comprehension – acknowledge what you hear
   - Be aware of how you react
   - Verbalize your plans

2. Reluctance to simplify interpretations
   - Take nothing for granted
   - Encourage team members to express different points of view (psychological safety)
   - Basic idea
   - We see what we expect to see
   - We see what we have labels to see
   - We see what we have skills to manage
   - Our expectations help us simplify our world and steer us away from disconfirming evidence
3. HROs are preoccupied with all failures
   • Large and small
   • Small things are often early warning signals
   • Opportunity to learn fix and manage
   • Learning from failure is hard
     – Requires psychological safety
     – Learning culture
     – Teamwork & communication

4. Deference to expertise
   • Who are our experts?
   • Does your team know who has the expertise to respond
   • Does your organization value expertise and experience over hierarchical rank?
   • HROs shift decisions away from formal authority toward expertise and experience
   • Flexile decision making – not a single central player
5. Resilience

- The capacity to recover quickly from difficulties; toughness.
- The process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress.
- Ability to bounce back.

5. Commitment to resilience

- Resilience can benefit patient safety efforts because it represents a change in emphasis from a traditional, reactive focus on errors to seeing humans as a defense against failure. SA Jeffcott.
- Improve more, or quickly develop new ways to respond to unexpected events.
- Quickly identify issues and have structures in place so we can immediately respond and minimize the harm.

5. Commitment to resilience

- Resilient teams have formal and informal contacts available to solve problems.
- Resilient teams:
  - Skilled at improvisation
  - Deep knowledge of basics
  - Recombine understandings on the spot
  - Adopt attitude of wisdom
  - More you know more you don’t know
  - Avoid overconfidence, over caution
  - Near miss = danger in disguise
  - Practice respectful interaction
  - Trustworthy
  - Trust others
  - Resolve differences respectfully.
5. Resilience

- **Bite Sized Resilience: Three Good Things**
- Brian Thexton – Duke Clinical Research Institute
- Simple resilience exercise
- Better than Prozac!
- Based on Martin Seligman's work - gratitude journal

HROs are Learning Cultures

- Learn from failure
- Apply learning to improve
- Return to normal operations quickly
- No question is a dumb question
- Everyone participates
  - Good Catches
  - Recognize unsafe conditions
  - Recognize systems failures

Team

- Noun
- Established, fixed group of people cooperating in pursuit of a common goal.
- Fundamentals of team work
  - Trust
  - Coordination
  - Foundation of familiarity through the careful sharing of personal history and prior experience,
  - Development of shared experiences through practice working together.
  - ample time to practice interacting successfully and efficiently.
TEAMING

- Teaming is a verb
- Dynamic activity
- Actively building and developing teams even as a project/shift is in process, while realizing that a team’s composition may change at any given moment.
- Relies on the foundations of teamwork without the shared experiences or practice
Teaming – the engine of organizational learning

- Pillars of effective teaming
  - Speaking up
    - Honest and direct conversation
    - Asking questions
    - Seeking feedback
    - Discussing errors
  - Collaboration
    - Mindset of collaboration to drive the process
  - Experimentation
    - Learning from results
  - Reflection
    - Critically examining the results of actions to assess and uncover new ideas

Successfully Teaming

Structure is necessary

- Role setting/role assignment
- Standard work
- Cognitive aids - like the aviation checklist,
- Benchmarked performance
- Psychological Safety
- Shared mental model
- Closed loop communication

“Most care delivered today is done by teams of people, yet training often remains focused on individual responsibilities… These silos created through training impede safety…”
Standard Work

Code Blue

Roles/Responsibilities Defined

- Physicians
  - Physician on duty serves as Code Blue Leader.
  - Physician on duty enrolls consultation services for Code Blue.
  - Physician on duty reserves consultation services for Code Blue.

- Critical Care Nurses
  - Critical Care Nurses designated by Critical Care Leadership.
  - Critical Care Nurses designated by Critical Care Leadership.

Code Blue Team Training

ZIEL Simulation Code Blue Training
Health System Code Blue Team Training

Time to Start Chest Compressions

A bad system will beat a good person every time.
W. Edwards Deming

Balanced accountability for both individuals and the organization
Psychological Safety

- Climate in which people feel free to express relevant thoughts and feeling
- A belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes
- Essential to learning
- Essential to teams
- Essential to a learning environment

Benefits:

- Encourages speaking up
- Enable clarity of thought by removing fear
- Supports productive conflict
- Mitigates failure – more common to report and discuss errors
- Promotes innovation – generates ideas
- Removes obstacles
- Increases accountability
Promoting psychological safety

Accountability for Behaviors

Framework for Clinical Excellence
“There are some patients whom we cannot help; there are none whom we cannot harm.”

-Arthur Bloomfield

References