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# 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.

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## 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

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## 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.

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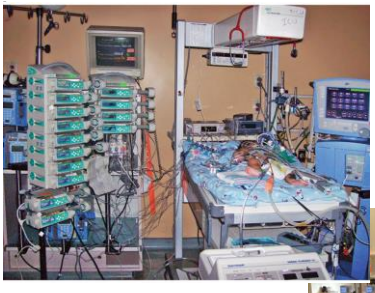
## Complexity of healthcare

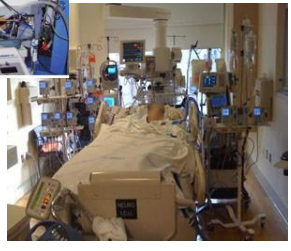
*Medicine used to be simple, ineffective and relatively safe*

*Now it is complex, effective and potentially dangerous*

*Sir Cyril Chantler*

*The role and education of doctors in the delivery of healthcare. Lancet 1999; 353 (9159): 1178-81, p.1181.*







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## 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?

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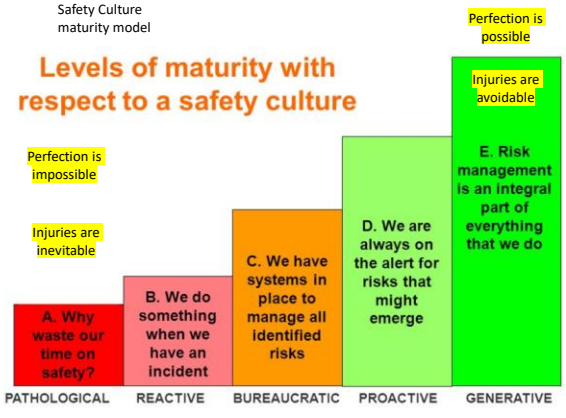
Safety Culture maturity model

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- Where are you now?
- Where do you want to go?
- **How do you get there?**



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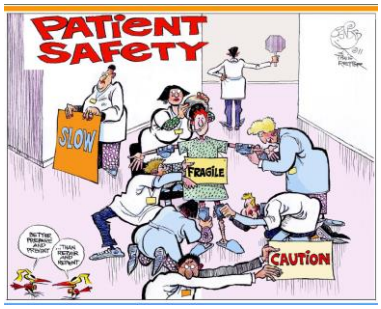
## Its so hard!

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


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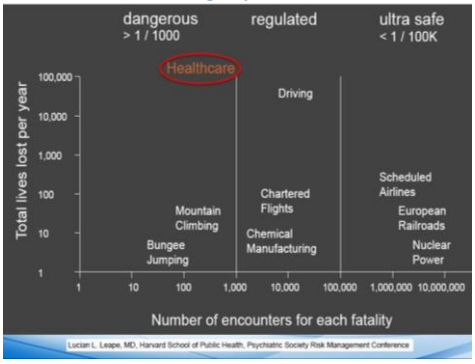
## Is healthcare highly reliable?



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## 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, 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



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## 1. Sensitivity to operations

- Build a clear picture of the situation
- Be familiar with operations beyond ones 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


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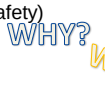
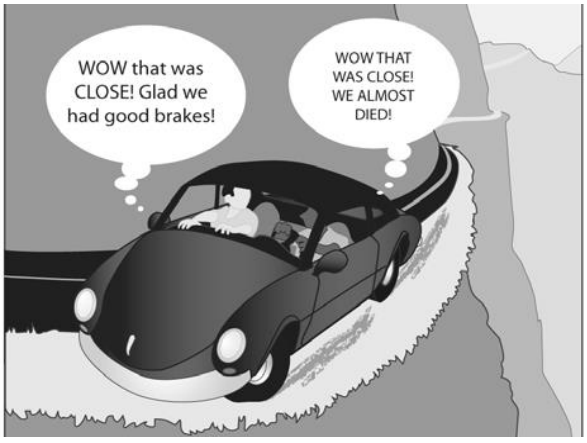
## 2. Reluctance to simplify interpretations



- 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





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## 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



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## 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

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## 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



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## 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 <u>seeing humans as a defense against failure</u>**. SA Jeffcott
- improvise 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.

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## 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

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## 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



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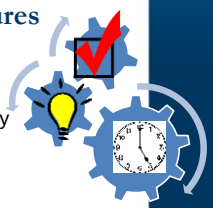
## HROs are Learning Cultures



- 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



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## 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.



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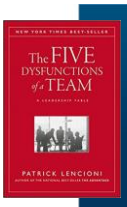


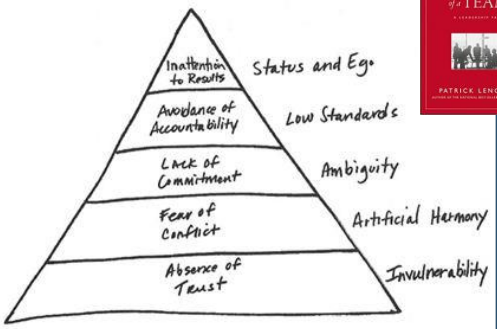


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## TEAMING

- 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 team work without the shared experiences or practice

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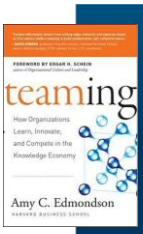
## Teaming – the engine of organizational learning




- 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

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## 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



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"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…"

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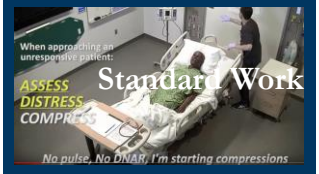



CODE BLUE COGNITIVE AID

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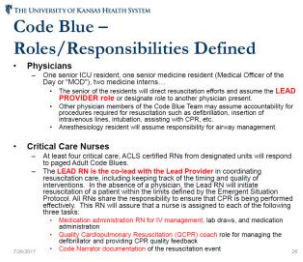
## Standard Work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Code Blue –
Roles/Responsibilities Defined

- **Physicians**
  - One senior ICU resident, one senior medicine resident (Medical Officer of the Day or "MOD"), two medicine interns…
    - The senior of the residents will direct resuscitation efforts and assume the **LEAD PROVIDER role** or designate role to another physician present.
    - Other physician members of the Code Blue Team may assume accountability for procedures required for resuscitation such as defibrillation, insertion of intravenous lines, intubation, assisting with CPR, etc.
    - Anesthesiology resident will assume responsibility for airway management.
- **Critical Care Nurses**
  - At least four critical care, ACLS certified RNs from designated units will respond to paged Adult Code Blues.
  - The **LEAD RN is the co-lead with the Lead Provider** in coordinating resuscitation care, including keeping track of the timing and quality of interventions. In the absence of a physician, the Lead RN will initiate Resuscitation for a patient within the limits defined by the Emergent Situation Protocol. All RNs share the responsibility to ensure that CPR is being performed effectively. This RN will assure that a nurse is assigned to each of the following three tasks:
    - **Medication administration RN for IV management**, lab draws, and medication administration
    - **Quality Cardiopulmonary Resuscitation (QCPR) coach** role for managing the defibrillator and providing CPR quality feedback
    - **Code Narrator documentation** of the resuscitation event

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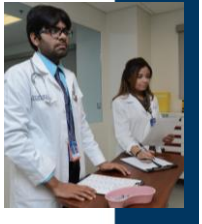
## Code Blue Team Training





ZIEL Simulation Code Blue Training

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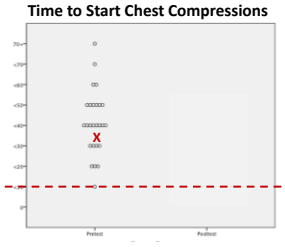
## Health System Code Blue Team Training

**Time to Start Chest Compressions**



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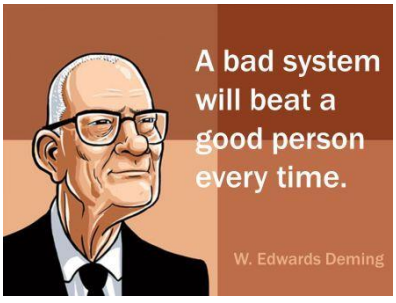


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## Balanced accountability for both individuals and the organization

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## 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 teaming
- Essential to teams
- Essential to a learning environment



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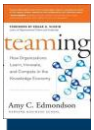
## Psychological Safety




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



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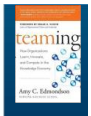
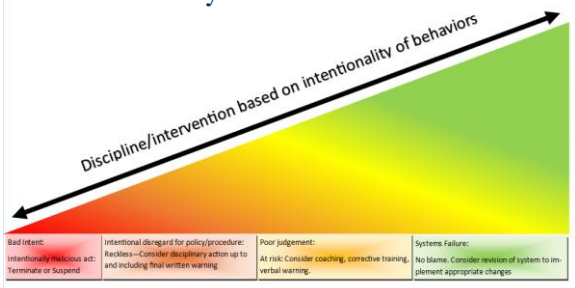


## Promoting psychological safety

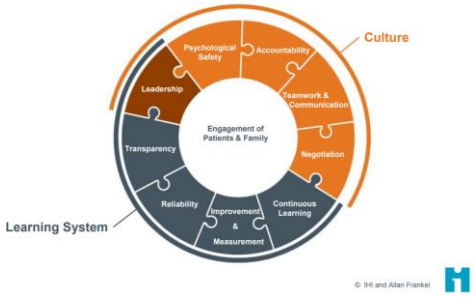
| Human Error | At-Risk Behavior | Reckless Behavior |
|---|---|---|
| *Product of Our Current System Design and Behavioral Choices* | *A Choice: Risk Believed Insignificant or Justified* | *Conscious Disregard of Substantial and Unjustifiable Risk* |
| Manage through changes in:<br>• Choices<br>• Processes<br>• Procedures<br>• Training<br>• Design<br>• Environment | Manage through:<br>• Removing incentives for at-risk behaviors<br>• Creating incentives for healthy behaviors<br>• Increasing situational awareness | Manage through:<br>• Remedial action<br>• Punitive action |
| **Console** | **Coach** | **Punish** |

## Accountability for Behaviors




## Framework for Clinical Excellence

Patient Safety



*"There are some patients whom we cannot help; there are none whom we cannot harm."*

-Arthur Bloomfield



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