The Human Factor: The Critical Importance of Teamwork & Communication in Providing Safe Care

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Moderator: Declan O'Neill

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9:30 – 11:30
Session Objectives (1030 – 1215)

• Identify effective techniques helpful to achieve cultural change
• Discuss the benefits of developing a standardized communication process in the care of patients
• Describe the process by which a ward can implement SBAR
Thesis Statement of this Presentation

- Effective communication and teamwork is essential for the delivery of high quality, safe patient care.
  - Communication failures are an extremely common cause of inadvertent patient harm. The complexity of medical care, coupled with the inherent limitations of human performance, make it critically important that clinicians have standardized communication tools, create an environment in which individuals can speak up and express concerns, and share common “critical language” to alert team members to unsafe situations.

- What beliefs do you have regarding communication and teamwork based on your experiences?
Human Error

1. Errors are common
2. The causes of errors are known
3. Systems failures are the “root causes” of most errors
   
   Lucian Leape, “Error in Medicine” JAMA, 1994

Besides breakdowns in teamwork and communication, what other failures in the system are commonly associated with preventable harm?
What Every Major Accident Seems to Have at its Roots...
Every System Is Perfectly Designed to Produce the Results it Gets....
Error-Producing Conditions

- Unfamiliarity with task x17
- Shortage of time x11
- Poor communication x10
- Information overload x6
- Misperception of risk (drift) x4
- Inadequate procedures / workflow x3

These are compounded by “human factors violations” such as fatigue, stress, work environment (e.g., psychologically unsafe environment), interruptions and distractions, and ambiguity regarding roles and responsibilities.
Violation Producing Conditions

- Perceived low likelihood of detection
- Inconvenience
- Misperception or lack of recognition of risk
- Authority / status to violate (self-perceived)
- Copying behavior
- No disapproving authority figure present
- Group pressure

(Primary Source Human Error Assessment & Reduction Technique, Jeremy Williams)
How About Our Own Conscious Violations?
Human Error Reduction Strategies

“When it comes to shaping on-the-job performance, there are 2 things that leaders can influence: The design of work processes staff use and the behavioral choices they make to accomplish their work. Both affect patient safety (and workplace safety and service and affordability and...)

- adopted from David Marx

What behavioral choices related to patient safety do you want healthcare professionals to make?
The Vital Behaviors of Front Line Staff that Support a Safe and Caring Environment

“Vital Behaviors” of Front Line Staff:

- Follow procedures and practices that create safety
- Ask for help when needed
- Offer help when someone else needs it
- Speak up
The Leader’s Role

What do leaders need to do to “shape” the behavioral choices described on the last slide?

• Ensure policies, procedures, and practices are “available, workable, intelligible, and correct”
• Build a psychologically safe and “Just” culture
• Coach the behaviors, skills, and practices you want
• Create transparency of performance and facilitate learning from disappointing experiences, mistakes, and adverse outcomes
Standard, Reliable Work-flow: Available, Intelligible, Workable, and Correct

A. Standardize and simplify the process
B. Use “controls” to prevent errors
C. Use mitigation strategies to interrupt errors that slip through A and B
Safety Culture Defined

Shared values and beliefs that interact with an organization's structures and control systems to produce behavioral norms.
Why is Safety Culture Important?

• It is often difficult for staff to speak up if they perceive a problem with patient care
• Disagreements in the unit are not always resolved appropriately (i.e., not who is right, but what is best for the patient)
• It is not always easy for personnel to ask questions when there is something they don’t understand
• It is often difficult to learn from the mistakes of others
• Management does not rapidly and reliably respond to disruptive behavior
Why is it Important to Measure?
People Act in Context

The context most physicians and many nurses “grew up” in:

1. Errors were viewed as personal failings – leading to self-blame, shame, and fear
2. The focus on individual responsibility inhibited systems thinking, the questioning of colleagues, and the belief that teams are collectively accountable for outcomes
3. A strong hierarchy made it very difficult to challenge a process or speak
4. A cloak of secrecy discouraged transparency and inhibited disclosure
Safety Culture Change

So, what experiences need to be created for healthcare professionals to shape their values and beliefs in a way that produces desired actions (i.e., desired behavioral norms)?
Eight Techniques to Achieve Culture Change

• Educate staff on human error, safety science, and systems thinking. Conduct team training to include a focus on teamwork and communication
• Design the consequences of desired behaviors to be soon, certain, and positive
• Coach
• Create psychological safety for staff and patients alike
• Round, recognize, and respond
• Adopt “Just Culture” principles to assess culpability and hold staff accountable for their behavioral choices
• Implement routines / processes that make it easy to learn from the mistakes of others
• Meet the Face of Harm...Take Care of the “Second Victim”
Teamwork and Communication
What High Reliability Organizations (HROs) Have Taught Us

Organizations that experience few catastrophic mishaps despite an inherently risky environment

- Conditions are rife with complexity, interdependence, and time pressure

Examples:

- Aircraft carrier flight deck operations
- Nuclear power plants
- Submarine operations
- US Forest Fire Service
How HRO Principles Guide HRO Teamwork and Communication Practices

1. Preoccupation with failure
   Example: Cross-checking

2. Reluctance to simplify
   Example: Readbacks and Call-outs

3. Commitment to resilience
   Example: Critical language for critical times

4. Deference to expertise
   Example: Flattening the hierarchy

5. Sensitivity to operations
   Example: Simple, structured, standard language
Teamwork

Team:
A group with complementary skills who are committed to a common purpose for which they hold themselves mutually accountable

Teamwork:

• Grounded in mutual respect
• Requires clear exchange of information that result in appropriate action
• Benefits from well-defined roles and responsibilities
• Builds over time with training and feedback
Thinking of teams you have been on....

• Good teams: What does it take for teams to be successful and high-performing?
• Poor performing teams: What got in the way of success?
Leaders Create the Environment for Success

Effective Leaders:

- Set the stage actively and positively.
- Use peoples names.
- Flatten the hierarchy.
- Share the plan.
- Continuously invite the other team members to offer input and voice concerns.
Example of Leadership

“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.”

- Vascular surgeon doing new, complicated procedure
- Endovascular aortic stent – in CV lab
Communication
Communication

• Breakdowns in communication may be the single most important factor to preventing patient injury.
• Virtually all instances of unexpected adverse events involve communication failures.

Someone somewhere knew something...
...that could have impacted the outcome
Communication Skills that can Avoid and/or Mitigate Harm

- **Briefing:** A conversation and dialogue (two-way) of concise and relevant information
- **SBAR:** A structured method to communicate important information in a succinct manner for the purpose of getting action
- **Assertion (including “Critical Language”):** To have individuals speak up, and state their information with appropriate persistence until there is a clear resolution.
- **Readbacks:** To ensure that verbal instructions between healthcare professionals were heard and understood
- **Debriefing:** Team-based discussion & review of a shared experience to learn from
- **Callouts:** The vocalization of information that is known by one team member, for the benefit of other team members
What Has Been Your Experience?

- What has been your experience in using standardized communication processes in patient care?
- What have the benefits been?
- How about any negative consequences?
Assertion - What it’s Not
Assertion – What it is

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

GET PERSON’S ATTENTION

EXPRESS CONCERN

STATE PROBLEM

PROPOSE ACTION

REACH DECISION

ESCALATE (if necessary)

2 Challenge Rule
Situational Brief: SBAR

• Situation (the problem, what is going on)
• Background (pertinent, brief, related to the point)
• Assessment (what you found / think is going on)
• Recommendation (what you want, request/recommend)
  • Followed by respectful response, discussion, and plan!
SBAR: How to Help Your Colleagues Get Fluent

- Take 5 minutes
- Use case studies and work with a partner to provide
  - Situation (the problem, what is going on)
  - Background (pertinent, brief, related to the point)
  - Assessment (what you found/think is going on)
  - Recommendation (what you want, request/recommend)

Debrief together
Steps to Consider When Trying to “Hardwire Hard Stuff”

...Like SBAR
Focus on Planning Rapid Tests Under Varying Conditions

Model for Improvement developed by Associates in Process Improvement (http://www.apiweb.org)
Practical Exercise: Debriefing

Take a moment to reflect on my teaching style and your experience over the past 90 minutes or so.

- What went well?
- What didn’t work as well?
- What would you recommend differently next time?
Summary: Successful Teams

• Have clear roles, goals and objectives
• Communicate well and often
• Respect and listen to each other
• Realize that patients and members are an essential part of the team and engage them
• Shape the culture by the experiences they create to get the outcomes they want for their patients and themselves
What Questions Do You Have For Me?
“We can’t change the human condition, but we can change the conditions under which humans work.”

--James Reason