Keeping Patients Safe: Focus on Team Communication

Advancing Nursing Practice
Nursing Symposium - April 28, 2005

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In the autumn of 1995, a radar operator aboard a U.S. aircraft carrier off Newfoundland signaled the bridge that their ship was on a collision course with a Canadian vessel. The captain got on the radio and the following exchange ensued...

(Internal Bleeding, 2004, Robert M. Wachter, M.D.; Kaveh G. Shojania, M.D.)
U.S. Captain:
“Please divert your course five degrees to the south to avoid collision.”

Canadian Radio Operator:
“Recommend you divert your course fifteen degrees north to avoid collision.”

U.S. Captain:
“This is the captain of a U.S. naval vessel. I say again, divert your course.”

Canadian Radio Operator:
“No, sir. I say again, divert your course!”

U.S. Captain:
“This is the aircraft carrier U.S.S. Coral Sea. We are a large warship of the United State Navy. Divert your course now!!!!”

Canadian Radio Operator:
“This is a lighthouse. Your call.”

--- The Lighthouse Parable

Clearly, we must do much more to create a collaborative culture in health care – one in which all providers at all levels feel free to report and learn from their mistakes, act in concert, and voice their concerns while there is still time to do something about them.

This new culture will require substantial new training, in-service coaching, and patience. Physicians in particular have to see themselves in a new light: not as “captain of the ship,” but as an integral part of a multidisciplinary team in which no role, or voice, can safely be ignored.

(Internal Bleeding, 2004, Robert M. Wachter, M.D.; Kaveh G. Shojania, M.D.)
Concern About Patient Safety….Deja vu

“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.”


“Even admitting to the full extent the great value of the hospital improvements of recent years, a vast deal of suffering, and some at least of the mortality, in these establishments is avoidable.”

(Florence Nightingale)
Concern About Team Communication…. Relatively New

First of all, PARC was fundamentally non-collaborative . . . .
There was surprisingly little cross-disciplinary work. There were turf wars and physicists, for example, weren’t allowed to talk with computer scientists. . . . .
To me the white space between fields is . . . .
The place to explore . . . .
If you get multiple disciplines together working, around the root of a problem, it pulls you out of your own discipline and fuses different points of view that lead to a reframing.

(J. Brown, Former Director, Xerox Palo Alto Research Center)
Quality Problems

- Overuse
- Underuse
- Error
Definitions

- **Error:**
  - Failure of a planned action to be completed as intended (error of execution), or the use of a wrong plan to achieve an aim (error of planning) *(adapted from Reason, 1990)*
  - An opportunity to fire someone. An opportunity to fix the system *(J. Turnbull)*

- **Patient Safety:**
  - Freedom from accidental injury

- **Errors occur because of system failures**

- **Preventing errors means designing safer systems of care**

Institute of Medicine (IOM), 1999
**Crossing the Quality Chasm**

“... the health care environment should be safe for all patients, in all of its processes, all the time. This Standard of Safety implies that organizations should not have different, lower standards of care...”

**Health Care Errors are likely when:**

- Multiple, varied interactions with technology
- Many individuals involved in care/multiple handoffs
  - Increasingly complex systems with a mix of players (MD’s, RNs, patients, others)
- High acuity of illness
- Environment prone to distraction
- Inherent uncertainty
  - Need for rapid decisions, time pressure
  - High volume, unpredictable patient flow
Six Aims for Improvement

• SAFE
• Effective
• Patient Centered
• Timely
• Efficient
• Equitable

Institute of Medicine (IOM), 1999

Who is Making Patient Safety Their Business?

✓ State and Federal Policymakers
✓ Purchasers
✓ Media
✓ Health Care Clinicians, Systems and Related Organizations
✓ Consumers
“I ask Congress to move forward on a comprehensive health care agenda with… Improved information technology to prevent medical error and needless costs…”

(G.W. Bush, State of the Union Address, 2005)
THE WALL STREET JOURNAL.

The Informed Patient / By Laura Landro

Medication Errors Can Occur Outside Hospital

Health care providers are under increasing scrutiny to improve patient safety. Yet despite initiatives nationwide to reduce medical errors, the problem persists.

Many of the nation's leading hospitals and health care providers have taken steps to address the issue, but some experts say more needs to be done.

One of the most common causes of medical errors is the incorrect administration of medications. This can happen when the wrong medication is given, the wrong dose is given, or the medication is given at the wrong time.

To help reduce medical errors, the new Medicare law includes provisions for adoption of standards by 2010 for "de-prescribing," so that doctors can electronically monitor prescriptions directly to local pharmacies via the Internet, eliminating the search for errors.

In the meantime, there is a growing use of safety nets to catch drug errors. At Emory University, doctors are beginning to step up safety protocols.
Why will team communication increasingly garner attention?
1970’s Early Crew Characteristics

➢ Crew Flaws
  ✓ Inadequate Leadership
  ✓ Poor Cockpit Management
  ✓ Poor Followership
  ✓ Poor Group Decision-Making
  ✓ Poor Communications

➢ No Training

Results of Poor Human Factors

• 60-80% Hull loss accidents attributable to Flight Crew (Orlady)

• Non-Technical
  Lack of Flying Skills—typically not a factor

1978: United 173
Portland, OR
“The current no margin-no mission era in health care is … giving way to a new no outcome-no income era. Revenue will no longer be automatic, it will increasingly be linked to verifiable performance.”

(Denham, NPSF, 2004)

**Root Causes of Sentinel Events….. One Indicator of Performance (All categories; 1995-2002)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent of events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>60</td>
</tr>
<tr>
<td>Orientation/training</td>
<td>55</td>
</tr>
<tr>
<td>Patient assessment</td>
<td>50</td>
</tr>
<tr>
<td>Availability of info</td>
<td>40</td>
</tr>
<tr>
<td>Staffing levels</td>
<td>35</td>
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<tr>
<td>Physical environment</td>
<td>30</td>
</tr>
<tr>
<td>Continuum of care</td>
<td>25</td>
</tr>
<tr>
<td>Competency/credentialing</td>
<td>20</td>
</tr>
<tr>
<td>Procedural compliance</td>
<td>15</td>
</tr>
<tr>
<td>Alarm systems</td>
<td>10</td>
</tr>
<tr>
<td>Organization culture</td>
<td>5</td>
</tr>
</tbody>
</table>
Rural Health Professions Education

All health professionals should be educated to deliver:

- Patient-centered care
- Interdisciplinary team care
- Evidence-based practice,
- Quality improvement approaches,
- Informatics.
Achieving safe high quality care is predicated in large part on Team Communication

- Hardware
- Software
- Humanware

Why interdisciplinary teams?

- Response to complex challenges: acute critical care, care of chronic illness, geriatric care, palliative care
- Reduce redundancy
- Develop more creative solutions
- Higher quality/lower cost, better adherence to protocols, reduction in error?
Team function requires

• Knowledge
• Skills
• Attitudes
• AND a supportive workplace environment

Team function

• Common understanding and language
• Communication skills
• Conflict resolution skills
• [Group process skills]
• [Leadership skills]
Common understandings

• Terms (e.g., evidence-based practice, patient-centered care)
• Roles of different professions
• Specific experience/skills of individuals
• Goals -- may differ for different professions
• Some explicit discussion helps

Roles

• Knowledge: what other do
• Attitudes
  – Respect for others’ roles
  – Comfort with “role blurring”
Communication skills

• Giving
  – Open direct communication
  – Accurate and timely information reaches those who need it – lesson from aviation is that this is not always easy
  – Negotiation skills

• Receiving
  – Listening
  – Openness to communication from others

• “The doctor-nurse game” (1967)
• “The doctor-nurse game revisited” (1990)
  – Independent action
  – Undisguised recommendations
  – Direct communication
  – Assertion of equal importance of nursing role
  – May lead to open conflict, so → conflict resolution skills necessary
We can learn from aviation: Crew Resource Management (CRM) Techniques:

- Readbacks
- SBAR describe the:
  - Situation
  - Background
  - Assessment
  - Recommendation

(Institute of Healthcare Improvement, 2004)

Good communication requires

- Skills
  - Open communication
  - Giving negative/unwanted feedback in a way it will be heard
  - Dealing with conflict
- Attitudes
  - Confidence in professional role
  - Openness to new input, even if unpleasant or unwanted
  - Respect for others
Attitudes and values

- Respect for the contribution of other professions/professionals
- Acceptance of role overlap and blurring
- Confidence/willingness to give unwanted information
- Openness to new information and ideas
- Acceptance of role as part of a team, not “lone eagle” or “captain of ship”

Safety Culture Definition

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.

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.

(Organizing for Safety: 1993)
Creating A Culture Of Safety In Health Care Organizations

• Executive and Board Leadership
• Job design
• Create a learning environment
• Investment in Technology
• Promote effective team functioning

Learning Environment:

Asking - WHY? and HOW?

Takes you to different problems and ultimately different solutions

Than asking - WHO?
New Efforts….

- NQF – Mortality Measures, Coordination of Care Measures
New Efforts….2005 JCAHO National Patient Safety Goal

Goal 2: Improve the effectiveness of communication among caregivers

New Efforts….  
- Safety Climate Survey - Institute for Healthcare Improvement  
- Hospital Survey on Patient Safety Culture - Institute for Healthcare Research and Quality
New Efforts….100,000 Lives Campaign

Commitment to implement changes in care that have been proven to prevent avoidable deaths.

SIX Changes:

1) **Deploy Rapid Response Teams**
2) Deliver Reliable, Evidence-Based Care for Acute MI
3) Prevent ADE’s
4) Prevent Central Line Infections
5) Prevent Surgical Site Infections
6) Prevent Ventilator-Associated Pneumonia

(www.ihi.org)

A copy of this powerpoint presentation is available on the Center for Rural Health website: http://medicine.nodak.edu/crh