Leadership Checkpoint: Analyzing your Team Communication

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July 30, 2016
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Mr. Nguyen has over 30 years of experience in leadership positions at nursing homes, acute care hospitals, physician practices, insurance companies, and a law firm. He has presented numerous risk management educational seminars to medical societies, physician groups, hospital medical staff members, medical management associations, and medical schools.
After completing this activity, learners will be able to:

- Identify the impact of communication as a risk factor in healthcare safety and litigation.
- Recognize how communication techniques play an important role in highly functioning ambulatory practice teams.
- Describe three leadership techniques to enhance the effectiveness of your teams.
Materials used in this presentation are adapted with permission from TeamSTEPPS®, Agency for Healthcare Research and Quality; Rockville, MD, www.teamstepps.ahrq.gov
Coming together is a beginning;
Keeping together is progress;
Working together is success.

Henry Ford
COMMUNICATION AFFECTS CLAIMS

3,431 claims

Communication among providers
11%

Communication between patient/family and provider
15%

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WHY CARE ABOUT TEAMS?

- Provide quality care
- Optimize resources
- Resolve conflicts
- Share information
AM I PART OF A TEAM?

- Multiple opportunities for teamwork
  - Hospital department
  - Rapid response/Code team
  - Patient care teams
  - Office-based team
WHY DOES TEAMWORK MATTER?

- Better continuity of care
- Better access to care
- Improved patient satisfaction
- Higher patient-perceived quality of care
TEAM OBSTACLES

- Lack of information sharing
- Hierarchy
- Miscommunication
- Lack of Role Clarity
- Misinterpretation of Cues
- Workload
- Fatigue
- Distractions
- Lack of Coordination
TeamSTEPPS®: WHAT IS IT?

Team *Strategies and Tools* to *Enhance Performance* and *Patient Safety*

- Evidence-based
- 25 years of research
  - Military, aviation, nuclear power, business, industry
- Developed by:
  - Department of Defense’s Patient Safety Program
  - Agency for Healthcare Research and Quality (AHRQ)
Optimize patient outcomes by improving communication and teamwork skills
TeamSTEPPS® PRINCIPLES

• Communication
• Leadership
• Situational Monitoring
• Mutual Support
COMMUNICATION
Continuous process of keeping the team on the “same page”
Accomplish through use of communication tools:
- SBAR+R
- Call Outs
- Closed Loop Communication
**SBAR+R EXAMPLES**

- **Situation:**
  - What is going on with the patient?
  - I am concerned about Mrs. L’s fetal heart rate tracing

- **Background:**
  - What is the clinical context?
  - First pregnancy, being induced for post-dates

- **Assessment:**
  - What do you think the problem is?
  - I think she is having late decelerations. I have stopped the Pitocin and she is on her left side with oxygen on.
SBAR+R EXAMPLES

- **Recommendation:**
  - What would you like to recommend or request?
  - Come in to evaluate her tracing. When can I expect you?

- **Response:**
  - What is the response to your request?
  - I will be there in 15 minutes
CALL OUTS

- Team members “call out” critical information during emergency situations
  - E.g., vital signs, cumulative blood loss, time elapse
- Benefits
  - Informs all team members simultaneously
  - Helps team members “stay on the same page”
  - Promotes anticipation of next steps
  - Creates opportunities to clarify or update plan

What information would you want called out?
CLOSED LOOP COMMUNICATION

- **Sender**
  - Make a request or gives an order
  - Directed to a specific individual
  - Using name or eye contact

- **Receiver**
  - Accepts the message by repeating request

- **Sender**
  - Verifies that the message was received correctly

- **Receiver**
  - Confirms completion of the task
Leaders influence team effectiveness by:

- Facilitating team actions
- Ensuring that roles and tasks are understood by all team members
- Ensuring that teams have the necessary resources for optimal performance
- Being knowledgeable of team members' skills and expertise to allocate tasks and material resources
LEADERSHIP STRATEGIES

- **Briefs** = planning
- **Huddles** = problem solving
- **Debriefs** = process improvement
THE BRIEF: PLANNING

- Short session *prior* to start
- Establish “Game Plan”
- Assign roles
- Establish Expectations
- Set climate/tone
- Anticipate outcomes
- Anticipate contingencies
THE HUDDLE: PROBLEM SOLVING

- Takes place at any time
- Update the “Game Plan”
- Re-establish awareness
- Reinforce plans in place
- Assess the need to adjust the plans
THE DEBRIEF: PROCESS IMPROVEMENT

- Takes place after the activity
- Review the “Game”
- Informal information exchange
- Improve team work
- Improve outcomes
Facilitated, open, and safe group discussion
- Uncovers collective intelligence
- Looks at performance, communications, and system issues objectively
- Encourages self-reflection
- Opportunities for collaborative problem-solving with respect
- Improves team performance, builds trust equity
Leadership Checkpoint: Analyzing your Team Communication
Actively scan for changing conditions:

- Patient
  - Change in vitals, labs, blood loss
- Team Members
  - Experience levels, capabilities, limitations
- Clinic/Office operational status
  - Manpower, equipment, supplies
- Yourself
  - Fatigue, illness, fear
• Example in the medical office
  - A patient comes in complaining about a sore throat, but it turns out she may have pneumonia

• Medical assistant using situational awareness
  - Status of the Patient: Patient has pneumonia
  - Team members: Physician isn’t available or at lunch
  - Environment: Need an exam room with oxygen
  - Appropriate reaction: Ask a nurse to come in and assess the patient and administer oxygen
I’M SAFE Checklist:

• I = Illness
• M = Medication
• S = Stress
• A = Alcohol and Drugs
• F = Fatigue
• E = Eating and Elimination
MUTUAL SUPPORT
MUTUAL SUPPORT

- The essence of teamwork
- Protects team members from situations that may reduce effectiveness and increase the risk of error

Photo courtesy of Paul Preston, MD, Kaiser Permanente
TASK ASSISTANCE

- Expected that assistance will be *sought* and *offered in the context of patient safety*
- Team members protect each other from work overload
- Team members foster a climate where it’s expected and respected
But *only* when appropriate

- I’m *Concerned*
- I’m *Uncomfortable*
- This is a *Safety Issue*
**TWO-RULE CHALLENGE**

- **Challenge one:**
  - Responsibility of every team member
  - Challenge any course of action that may place the patient at risk

- **Challenge two:**
  - If no response, or unsatisfactory response, the challenge must be repeated
  - The second time is to ensure it was heard
TEAMWORK FAILURE?

Do you remember a time, either in the office, in ambulatory care or inpatient care when poor teamwork contributed to a negative patient outcome?

A. Yes
B. No
CASE EXAMPLE #1

- 29-year-old morbid obese female to ER
  - Short of breath, anxiety, fatigue
  - busy day, ER short staffed
- Doctor quick exam
  - BP WNL, P 143, R 24, O2 93%, pain 9/10, patient joking having anxiety attack
  - Doctor allowed to return to waiting room, no documentation of exam
- Triage Nurse monitored VS every 1.5 hours x 3 – VS unchanged, pain 6/10
- Almost 6 hours after ER arrival taken to exam room
- C/o SOB on exertion, lightheaded
- EKG: incomplete right bundle branch block, S1, Q3, T3 pattern
- History: 20 hours driving previous day, calf cramp, BCPs, Family history PE
CASE EXAMPLE #1

- Ordered CT r/o PE; before CT, patient worsened
  - Pale, diaphoretic, labored breathing
  - Plan intubation with rapid induction, 15 minute delay for respiratory
  - Prior to intubation respiratory arrest, CPR

- To cath lab
  - Pulmonary angiogram showed massive pulmonary embolism
  - Intra-arterial TPA given
  - Improved then coded, died
CASE EXAMPLE #1
WHAT WAS LACKING?

- **Leadership**
  - Brief - how to handle short staffing/heavy patient load?
  - Huddles - to re-evaluate staff/patients
  - Debrief - after patient expired?

- **Situational awareness**
  - Triage nurse aware no improvement in VS, lack of communication to Doctor
  - Was nurse afraid to speak up/challenge Doctor about no exam bed?

- **Communication**
  - SBAR +R
CASE EXAMPLE #2

- 65-year-old male, history MI, CABGx2, cardiac cath-occluded grafts
- Telemetry next day, severe pain right groin/abdomen, low BP- start pressors
- US-small pseudoaneurysm common femoral artery; low HGB- start blood
- Consulted cardiothoracic surgeon
  - ordered blood, added Levophed to Dopamine, transfer to CCU
- Cardiothoracic surgeon accepted courtesy consult, did not do vascular surgery (no vascular surgeon on call)
CASE EXAMPLE #2

- CT surgeon called cardiology invasive – informed most retroperitoneal bleeds do not need surg – fluids, blood, CT when stable
- Two hours later - BP drop, tachycardic, diaphoretic
- Nurse called cardiologist who said call CT surgeon
- Nurse called CT surgeon who said many pages to answer (covering two hospitals) and would call cardiologist later
- Patient coded 2 hours later. Cardiologist and CT surgeon at bedside. Expired. Family informed. Then heart rate returned. Three hours later expired.
- Autopsy - perforated right iliac artery

(continued)
CASE EXAMPLE #2
WHAT WAS LACKING?

- Communication
  - SBAR +R

- Mutual Support
  - CUS words
  - Two-Challenge Rule

- Situational awareness
  - Nurse experience? Assessing to call supervisor, other physician?
  - Was nurse afraid to speak up/challenge Doctor?
CASE EXAMPLE #3

- 32 year old female with 7 month old, breastfeeding, taking birth control pills
- To OB/GYN requesting IUD placement, insistent to be done this visit.
- Usual nurse for Dr. busy so other nurse stepped in.
- IUD inserted. After procedure, Dr. learned nurse did not get consent or preg test (usual practice)
- Patient anxious to leave, Dr decided d/t breastfeeding and BCPs, ok not to do pregnancy test.
- 2 wks later to office with cramping. US=18 week intrauterine pregnancy
CASE EXAMPLE #3

- Patient with no menses since birth of new baby.
- Unsuccessful removal of IUD. Next day delivered stillborn. IUD in placenta.
- On IUD insertion visit the Electronic Health Record showed
  - Patient had never been pregnant
  - “GU exam WNL”
  - Questioned if this carried over from previous entry, did Dr. do exam?
CASE EXAMPLE #3: WHAT WAS LACKING?

- Communication
  - Failure to share information, handoff

- Leadership
  - Debrief to review how procedure done without consent or urine pregnancy test.
TOOLS TO ASSESS NEED

- Tools to assist
  - AHRQ Surveys of Patient Safety Culture
  - TeamSTEPPS Teamwork Perceptions Questionnaire (TTPQ)
  - Patient satisfaction surveys
  - Employee surveys
LEADERSHIP/PHYSICIAN BUY-IN

- Organization leadership / Physician leadership
  - Familiarity with teamwork concepts and benefits of training
  - Support for training
  - Participation in training
SUSTAINMENT

- Culture change
- Orientation for new staff
  - Rotating staff
- Measure improvements
- Sharing results
A TEAM SKILL FOR YOU

Poling Question

Which Team Strategy / Tool could you see implementing in your office?

1. SBAR +R, Call Out, Check Back (Communication)
2. Daily Briefs, Huddles, Debriefs (Leadership)
3. Task Assistance, Two-Challenge Rule (Mutual Support)
4. Situational Awareness (Situation Monitoring)
5. More than one/Multiple
SUCCESSFUL TEAMS

- Evidence-based teamwork skills
  - Assess areas for improvement
  - Deliver need-based education
  - Follow-up to measure improvement
  - Celebrate successes!
THANK YOU

We relentlessly defend, protect, and reward the practice of good medicine.