Institute *for* Healthcare Improvement

Teamwork and Culture

Aidan Fowler

Teamwork

Coming together is a beginning
Keeping together is progress
Working together is success
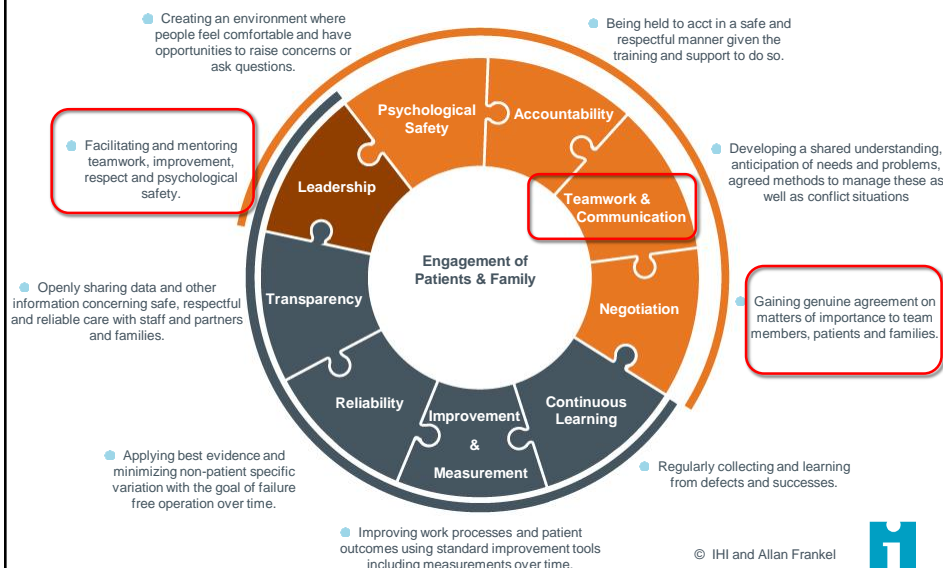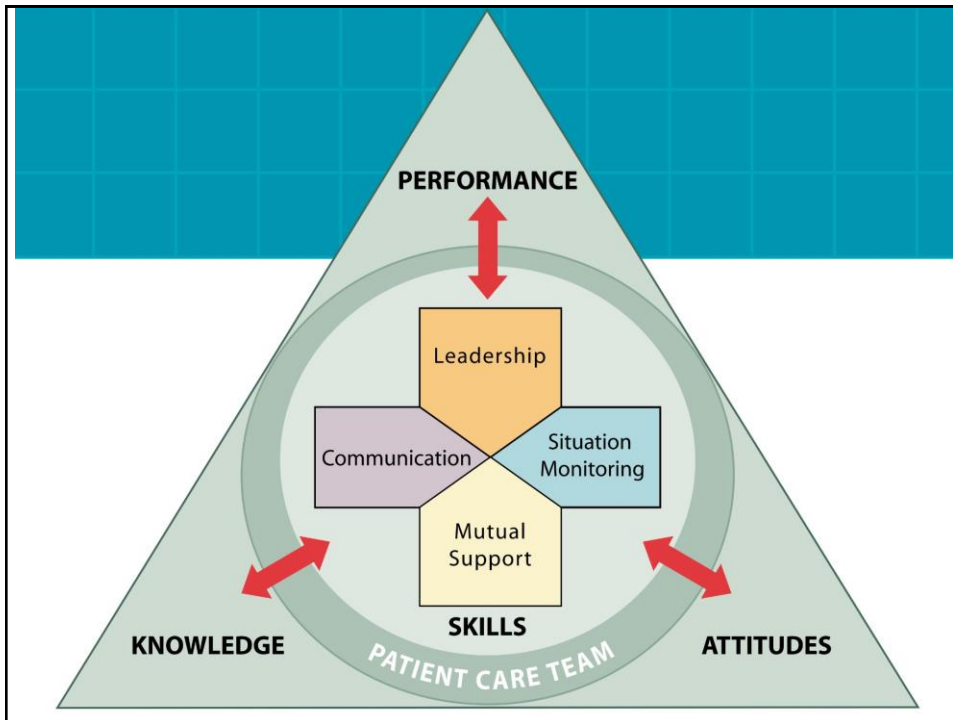
-Henry Ford

Together
Everyone
Achieves
More

"Human error in medicine, and the adverse events which may follow, are problems of psychology and engineering, not of medicine."
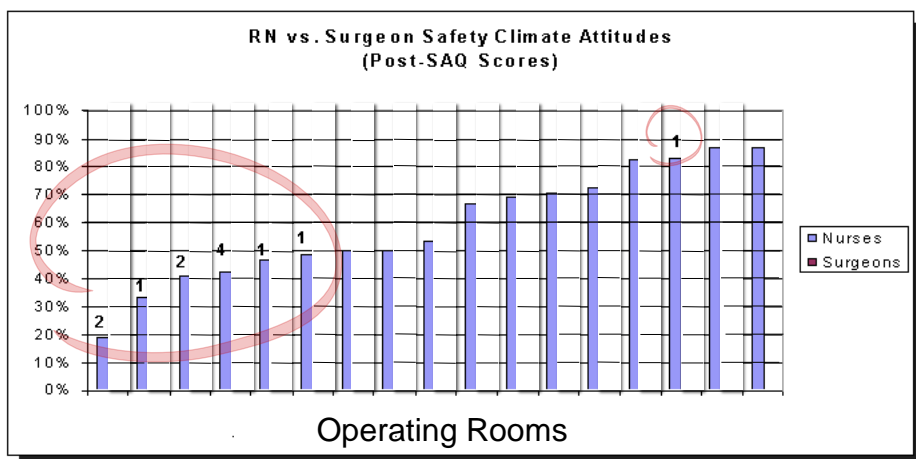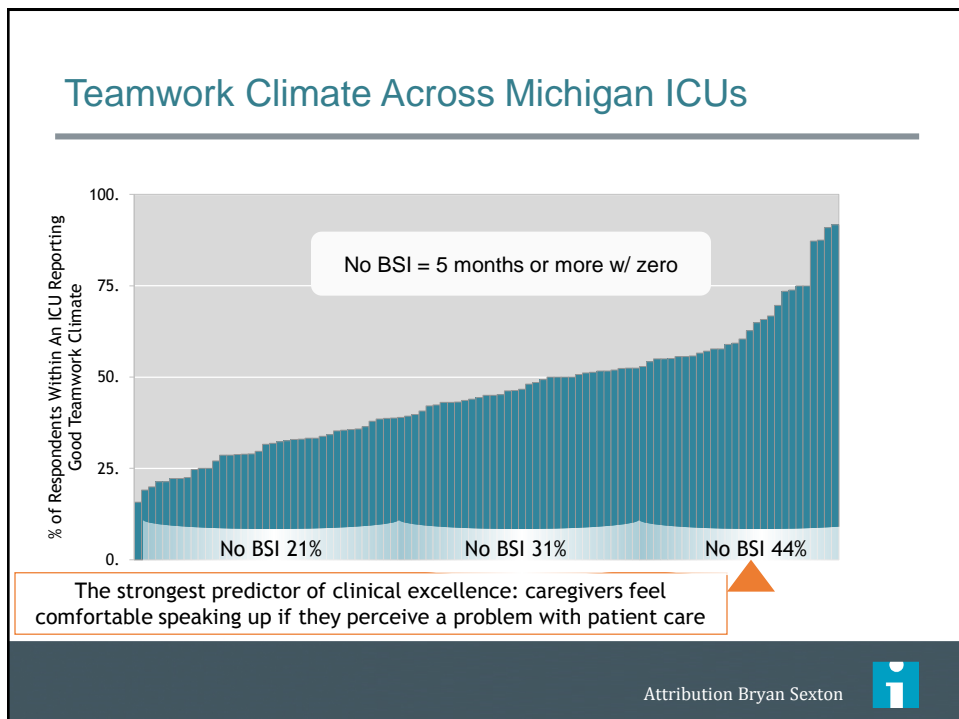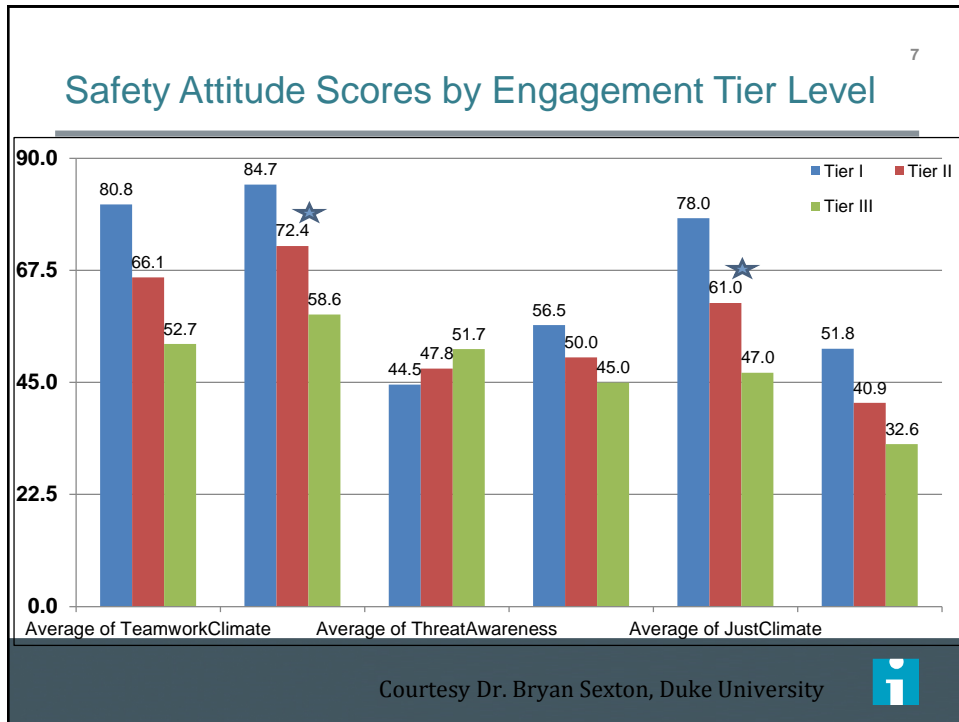
John Senders, 1993

Framework for Clinical Excellence

- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.

- Being held to acct in a safe and respectful manner given the training and support to do so.

- Facilitating and mentoring teamwork, improvement, respect and psychological safety.

- Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations

Psychological Safety

Accountability

Leadership

Teamwork & Communication

Engagement of Patients & Family

- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.

Transparency

Negotiation

- Gaining genuine agreement on matters of importance to team members, patients and families.

Reliability

Improvement & Measurement

Continuous Learning

- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.

- Regularly collecting and learning from defects and successes.

- Improving work processes and patient outcomes using standard improvement tools including measurements over time.

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Wrong Site Surgery or Retained Foreign Body in 17 Operating Rooms

Safety Attitude Scores by Engagement Tier Level

Legend: Tier I (blue), Tier II (red), Tier III (green)

	Tier I	Tier II	Tier III
Average of TeamworkClimate	80.8	66.1	52.7
(second group)	84.7	72.4	58.6
Average of ThreatAwareness	44.5	47.8	51.7
(second group)	56.5	50.0	45.0
Average of JustClimate	78.0	61.0	47.0
(second group)	51.8	40.9	32.6

Y-axis: 90.0, 67.5, 45.0, 22.5, 0.0

Courtesy Dr. Bryan Sexton, Duke University

Teamwork Climate Across Michigan ICUs

Y-axis: % of Respondents Within An ICU Reporting Good Teamwork Climate (100, 75, 50, 25, 0)

No BSI = 5 months or more w/ zero

No BSI 21%   No BSI 31%   No BSI 44%

The strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care

Attribution Bryan Sexton

Psychological Safety

Level	Description
GENERATIVE	Organisation wired for safety and improvement
PROACTIVE	Playing offence - thinking ahead, anticipating, solving problems
SYSTEMATIC	Systems in place to manage hazards
REACTIVE	Playing defense – reacting to events
UNMINDFUL	No awareness of safety culture

- Primary responsibility of leaders, continuously modelled everywhere.
- Leaders model and expect the behaviours that promote psychological safety
- In some units it feels safe to speak up and voice a concern
- Personality dependent – it depends who I'm working with
- Fear based – keep your head down and stay out of trouble

Psychological Safety

We are our own image consultants and best image protectors

To protect one's image, if you don't want to look

STUPID	**Don't ask questions**
INCOMPETENT	**Don't ask for feedback**
NEGATIVE	**Don't be doubtful or criticize**
DISRUPTIVE	**Don't suggest anything innovative**

PSYCHOLOGICAL SAFETY CHANGES THIS PARADIGM   Source: Amy Edmondson

NASA / UT Team skills

Briefing	Leadership / Followership / Concern for the Task
The effective briefing will be operationally thorough, interesting and will address co-ordination, planning and potential problems.	The extent to which appropriate leadership and followership are practiced..
Communication and Decision	Interpersonal Relationships / Group Climate
Reflects the extent to which free and open communication is practiced. Active participation in decisions encouraged.	Reflects the quality of relationships among the team, the overall climate in the workplace
Team Self Feedback	Preparation / Planning / Vigilance
The extent to which a team recognises the need to give and receive feedback.	Reflects the extent to which teams plan ahead, maintain situation awareness and anticipate contingencies.
Enquiry / Advocacy / Assertion	Workload / Distractions
Team members advocate, with appropriate persistence, the course of action they feel is best, even if it involves disagreement.	This is a rating of time and workload management. It reflects how the team distributes tasks, avoids overload and distractions.

Speeding Up Team Learning

The most successful teams adapt quickly to new ways of working. Now, a study of 16 cardiac surgery teams offers intriguing insights on how to make that happen.

CARDIAC SURGERY is one of medicine's modern miracles. In an operating room no larger than many household kitchens, a patient is rendered functionally dead – the heart no longer beating, the lungs no longer breathing – while a surgical team repairs or replaces damaged arteries or valves. A week later, the patient walks out of the hospital.

The miracle is a testament to medical technology – but also to incredible teamwork. A cardiac surgical team includes

by Amy Edmondson, Richard Bohmer, and Gary Pisano

cardiac surgery. What we found sheds light on one of the key determinants of team performance: a team's ability to adapt to a new way of working. In corporate settings, teams frequently have to learn new technologies or processes that are designed to improve performance. Often, however, things get worse – sometimes for a long time – be-

collaboratively instead of making contributions individually and then handing pieces of the project off to the next person.

Most teams become proficient at new tasks or processes over time. But time is a luxury few teams – or companies – have. If you move too slowly, you may find that competitors are reaping the

Effective Teamwork

|	
GENERATIVE Organisation wired for safety and improvement	• Teamwork and continuous learning deeply embedded and central to our culture
PROACTIVE Playing offence - thinking ahead, anticipating, solving problems	• Teamwork methodically taught and modelled across the organisation
SYSTEMATIC Systems in place to manage hazards	• Training and tools available, partial implementation
REACTIVE Playing defence – reacting to events	• Focus on teamwork awareness/training in response to adverse events
UNMINDFUL No awareness of safety culture	• If people would just do their jobs we'd have no problems
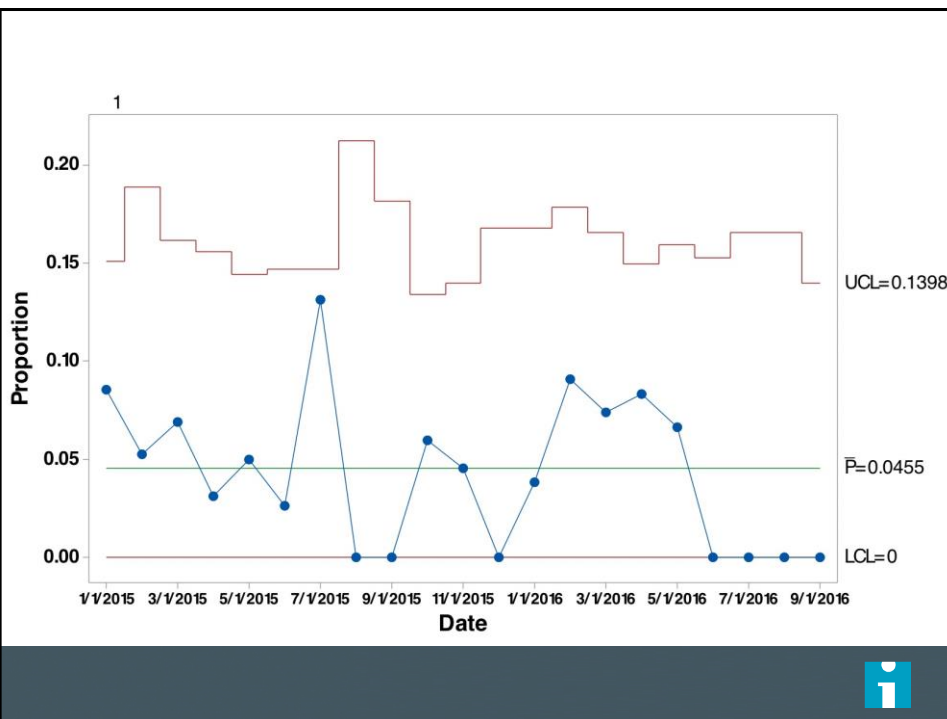
Think of your current team
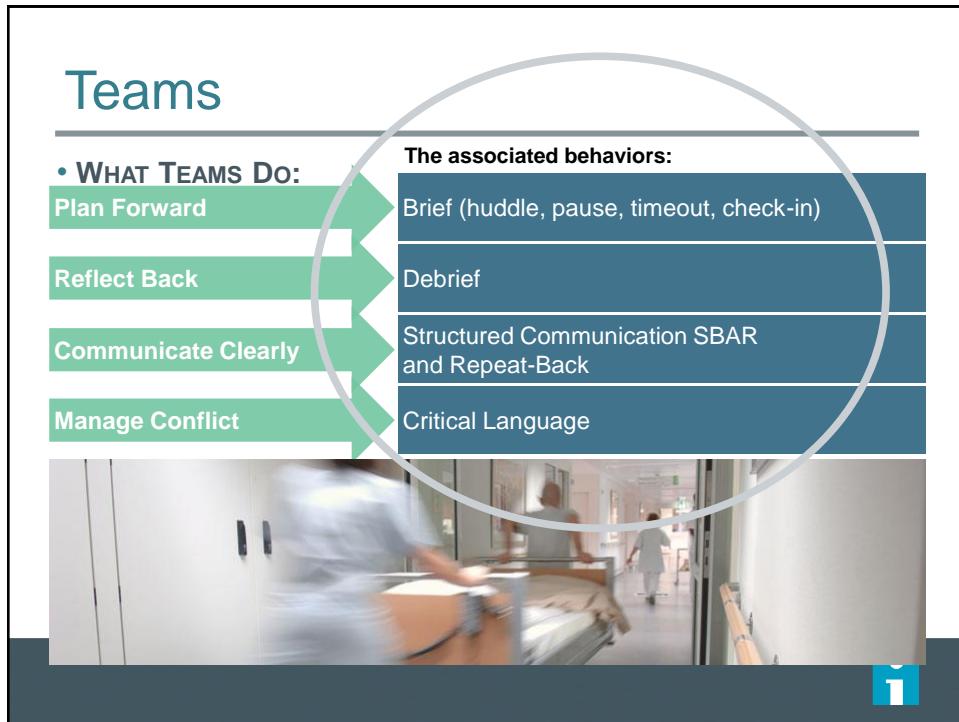
What keeps you from doing your job?

What barriers or challenges do you encounter?

Expertise & Teamwork

- Reacting to soft signals
- Everyone knows the plan and can act to safely execute
- Preoccupation with failure
- Commitment to resilience
- Deference to expertise
- Knowing where the failure modes are – learning from errors and near misses
- Never assuming safety – assuring it
- Help is available and psychologically safe always

Teams

• WHAT TEAMS DO:	The associated behaviors:
Plan Forward	Brief (huddle, pause, timeout, check-in)
Reflect Back	Debrief
Communicate Clearly	Structured Communication SBAR and Repeat-Back
Manage Conflict	Critical Language

What are the qualities of a good briefing or huddle?

Briefings

Briefings: Rounding, Pause, Timeout, Checklist, Huddle

4 COMPONENTS
- Everyone knows the **game plan**
- **Psychological Safety** is ensured
- **Norms of conduct** are discussed
- **Expectation of excellence** is set

- What is the role of debriefing?
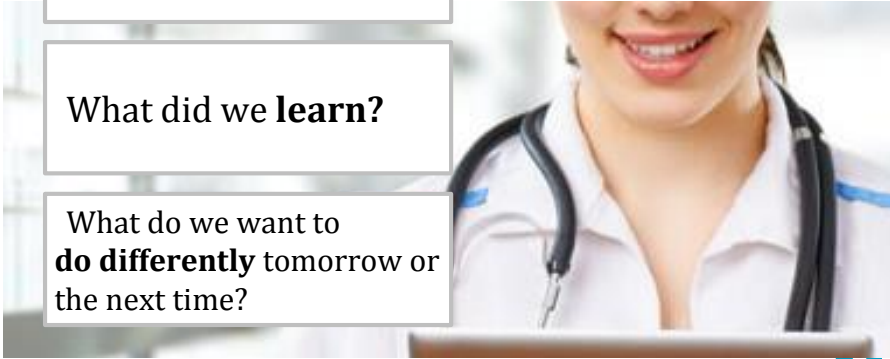- When should you debrief?

Debriefing

Ask three questions:

What did we **do well?**

What did we **learn?**

What do we want to **do differently** tomorrow or the next time?

Structured Communication

- SBAR: Situation, Background, Assessment, Recommendation
  - Links known facts with judgments and decisions
  - Designed to get the attention of others
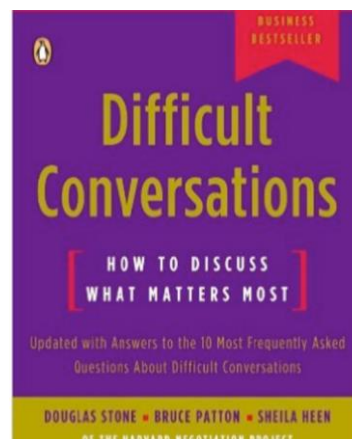 - Useful in negotiation

Critical Language

- A PHRASE THAT STOPS THE WORK
- "I need a little clarity."
- "I am concerned or unclear. This is unsafe."
- Or others!!

Difficult Conversations

- Never negotiate 1st person to 2nd person – it's much more threatening.

- Always use the 3rd person – anchor to an area of common agreement – the common goal – safe care of the patient

Depersonalise the Conversation

- What do we all want to see happen here?
- What does success for this patient look like?
- What needs to happen to achieve that outcome?
- What behaviours are necessary to achieve that goal?
- What does that mean to me and you?

CHAT

- Concern – share your fear
- Hope – state your intention
- Acknowledge – is that OK?
- Truth – my truth is…….

And finally…..

- What are your barriers to team working?
- What about the culture supports or prevents effective team working?
- To get you thinking differently please use a flip chart and a drawing to represent this………