Effective Teamwork

What Great Teams Do Well

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7 October 2015

Attribution for these slides to: Safe and Reliable Care LLC and Doug Salvador, MD
Framework for Clinical Excellence

**Patient Safety**

- Improving work processes and patient outcomes using standard improvement tools including measurements over time.
- Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.
- 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.
- Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.
- Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.
- Regularly collecting and learning from defects and successes.
- Gaining genuine agreement on matters of importance to team members, patients and families.
- Being held to act in a safe and respectful manner given the training and support to do so.

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Safety Cultures Evolve

Where Are You?

Attr: Patrick Hudson, Univ. of Leiden
SocioTechnical Framework

- Patient & Family Centered Care
- Leadership – Senior and Clinical
- Effective Teamwork
- Psychological Safety
- Organizational Fairness
- Reliable Processes of Care
- Learning System – Improvement
Effective Teamwork

- Teamwork and continuous learning deeply embedded and central to our culture
- Teamwork methodically taught and modeled across the organization
- Training and tools available, partial implementation
- Focus on teamwork awareness/training in response to adverse events
- If people would just do their jobs we’d have no problems

**GENERATIVE**
Organization wired for safety and improvement

**PROACTIVE**
Playing offense - thinking ahead, anticipating, solving problems

**SYSTEMATIC**
Systems in place to manage hazards

**REACTIVE**
Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture
Teamwork Domain

Disagreements in this work setting are appropriately resolved (i.e., not who is right but what is best for the patient). (14229)

Communication breakdowns are NOT common when this work setting interacts with other work settings. (14401)

Communication breakdowns are NOT common in this work setting. (14505)

Dealing with difficult colleagues is NOT consistently a challenging part of my job. (14472)

The people here from different disciplines/backgrounds work together as a well-coordinated team. (14581)

In this work setting, it is NOT difficult to speak up if I perceive a problem with patient care. (13981)

It is easy for personnel here to ask questions when there is something that they do not understand. (14609)

Source Data: June 2015
In this work setting, it is not difficult to speak up if I perceive a problem with patient care.

<table>
<thead>
<tr>
<th>Position</th>
<th>Percent Positive Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/Manager (5)</td>
<td>100</td>
</tr>
<tr>
<td>Other (31)</td>
<td>87</td>
</tr>
<tr>
<td>Physician: Resident (5)</td>
<td>80</td>
</tr>
<tr>
<td>Nurse (155)</td>
<td>75</td>
</tr>
<tr>
<td>Admin Support (Clerk/Secretary/Receptionist) (22)</td>
<td>73</td>
</tr>
<tr>
<td>Physician: Attending/Staff (52)</td>
<td>73</td>
</tr>
<tr>
<td>Nurses Aide (56)</td>
<td>64</td>
</tr>
<tr>
<td>Clinical Support (Medical Assistant, EMT, etc.) (19)</td>
<td>63</td>
</tr>
</tbody>
</table>

Source Data: June 2015

Position(s): All Positions
Teams

What teams do:

- Plan Forward
- Reflect Back
- Communicate Clearly
- Manage Conflict

The associated behaviors:

- Brief (huddle, pause, timeout, check-in)
- Debrief
- Structured Communication SBAR and Repeat-Back
- Critical Language
Briefings

Briefings: Rounding, Pause, Timeout, Checklist, Huddles

4 COMPONENTS

- Everyone knows the game plan
- Psychological Safety is ensured
- Norms of conduct are discussed
- Expectation of excellence is set
Read Backs

- Ensuring transmission and reception of information is clear and accurate, not assuming
- All drug names
- All numbers (patient ID, dosages, etc.)
- Clinical histories
- Handoff information
Critical Language

- We are going to stop every time and take one minute to make sure we’re doing the right thing.
- “I just need a little clarity.”
- “I am concerned or unclear. This is unsafe.”
Debriefing – Linking teamwork and Improvement

- What did we do well?
- What did we learn so we can do it better the next time?
- What got in the way that needs to be fixed?
The Impact Of Acting on Safety Culture Data In Rhode Island ICUs

<table>
<thead>
<tr>
<th>ICUs that DEBRIEFED</th>
<th>ICUs that did not DEBRIEF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflected on culture scores and took action</td>
<td>Did not reflect on SAQ scores nor take action</td>
</tr>
<tr>
<td>1. &gt;15% culture score increase in 5/7 domains</td>
<td>1. 5% culture score drop in 5/7 domains</td>
</tr>
<tr>
<td>2. &gt;10% BSI reduction</td>
<td>2. No reduction in BSIs</td>
</tr>
<tr>
<td>3. &gt;15% VAP reduction</td>
<td>3. 5% increase in VAPs</td>
</tr>
</tbody>
</table>

Effective Leadership

- Set a positive active tone
- Think out loud to share the plan – common mental model
- Continuously invite people into the conversation for their expertise and concern
- Use their names
Culture and Leadership
Local Leadership by Work Setting

(Percent of Respondents Reporting Good Local Leadership)
Disagreements in this work setting are appropriately resolved (i.e., not who is right but what is best for the patient).
An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

- 103 ICUs, all but 5 in Michigan
- 1981 ICU-months of data and 375,757 catheter-days
- 16-18 months of follow-up

“Keystone ICU project”
How did they do it?

- **Team Leaders** - the ICUs were asked to designate at least one physician and one nurse as Team Leaders

- Team Leaders were **instructed in the science of safety**, and in the interventions

- This **information was disseminated** among their colleagues

- **Training of the Team Leaders** was accomplished through
  - conference calls every other week
  - coaching by research staff, and
  - statewide meetings twice a year

- **The teams received supporting information** on
  - the efficacy of each component of the intervention
  - suggestions for implementing each component, and
  - instruction in methods of data collection

- **Team Leaders were partnered with their local hospital-based infection-control practitioners** to assist in the implementation of the intervention and to obtain data on catheter-related bloodstream infections at the hospital.
How did they do it?

- **Clinicians were educated** about practices to control infection and harm resulting from catheter-related bloodstream infections
- A **central-line cart** with necessary supplies was created
- A **checklist** was used to ensure adherence to infection-control practices
- **Providers were stopped** (in non-emergency situations) if these practices were not being followed
- **Removal of catheters was discussed** at daily rounds
- **Teams received feedback** regarding the number and rates of catheter-related bloodstream infection at monthly and quarterly meetings, respectively

In April 2004, a **letter and a baseline survey were sent to the chief executive officers** of the participating hospitals. The letter outlined the evidence supporting the use of chlorhexidine and asked the CEOs to stock chlorhexidine in their hospitals before implementing the study intervention.
The strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care.

No BSI = 5 months or more w/ zero

Attribution Bryan Sexton
Adaptive versus Technical Leadership

- Known v. unknown problems
- Differences in style
- Knowing when to shift your leadership style
Gary Klein – Expert Decision making

- Experts pattern match
- Quick and accurate as long as one tests
- Mental simulation is common and valuable – high performing teams simulate together
- What about the new people, the novices?
Effective Leaders

- Create psychological safety
- Calibrate drift to minimize shortcuts and workarounds
- Drive effective team performance
- Model the values and behaviors that create value and reduce risk
**Observation Page**

**Observer Name:**

**Area Observed (check one):**
- [ ] Breast IR
- [ ] Abd IR
- [ ] Chest IR
- [ ] Neuro IR
- [ ] Bone/MSK IR
- [ ] Vascular IR

**Observation Type (check one):**
- [ ] Conversation between providers
- [ ] Rounds
- [ ] Conversation with patient/family
- [ ] General Activity
- [ ] Procedure

**Behaviors**

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Rate Usage of Special Behaviors</th>
<th>Descriptive Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Ineffective ← → Very Effective</td>
<td></td>
</tr>
<tr>
<td>Briefing</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Inquiry &amp; Rebriefing</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Assertion &amp; Challenge</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Structured Communication</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Closing the Loop</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Debriefing</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

**Behaviors Guidelines**

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
<th>Rating = 1 Examples</th>
<th>Rating = 2 Examples</th>
<th>Rating = 3 Examples</th>
<th>Rating = 4 Examples</th>
<th>Rating = 5 Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefing &amp; Rebriefing</td>
<td>Formal task/actions briefing at the start of a procedure. Formal / distinct re-briefing when conditions change in the midst of a procedure.</td>
<td>Formal briefing does not occur when appropriate (e.g., start) Lack of game plan and discussions</td>
<td>Formal briefing is disorganized Components of formal briefing are incomplete Game plan is not always clear to all.</td>
<td>Names/roles &amp; procedure verified All know game plan Details, critical steps &amp; possible problems raised &amp; re-addressed</td>
<td>Importance of briefing emphasized All know the game plan all the time</td>
<td>Looks good All components seen Want to take a video</td>
</tr>
<tr>
<td>Closing the Loop</td>
<td>Confirmation that information was received by repeating the content of the information back to the sender (i.e., read back and hear back).</td>
<td>Requests, orders &amp; instructions never repeated Information is confused</td>
<td>Requests, orders, &amp; instructions seldom repeated even though it is pertinent</td>
<td>Pertinent requests, orders &amp; instructions are repeated back to the sender when recev'd</td>
<td>In addition to closing the loop, members note its importance</td>
<td>Looks good All components seen Want to take a video</td>
</tr>
<tr>
<td>Debriefing</td>
<td>Formal debriefing following a procedure that covers what went well, what went not so well, and what might be done differently in the future.</td>
<td>Debriefing does not occur when appropriate (e.g., end of procedure)</td>
<td>Debriefing does not cover relevant questions Debriefing does not yield clear takeaways</td>
<td>Debriefing held at end of procedure Debriefing generates clear takeaways</td>
<td>Debriefing exceptionally structured Members comment on importance of briefing</td>
<td>Looks good All components seen Want to take a video</td>
</tr>
</tbody>
</table>
Breast Imaging
Brief and Debrief
Construction Site Video
Vascular/NonVascular at Weekly Huddle
Framework for Clinical Excellence

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Take a moment to reflect on your own work. What will you incorporate from this session into your plans?