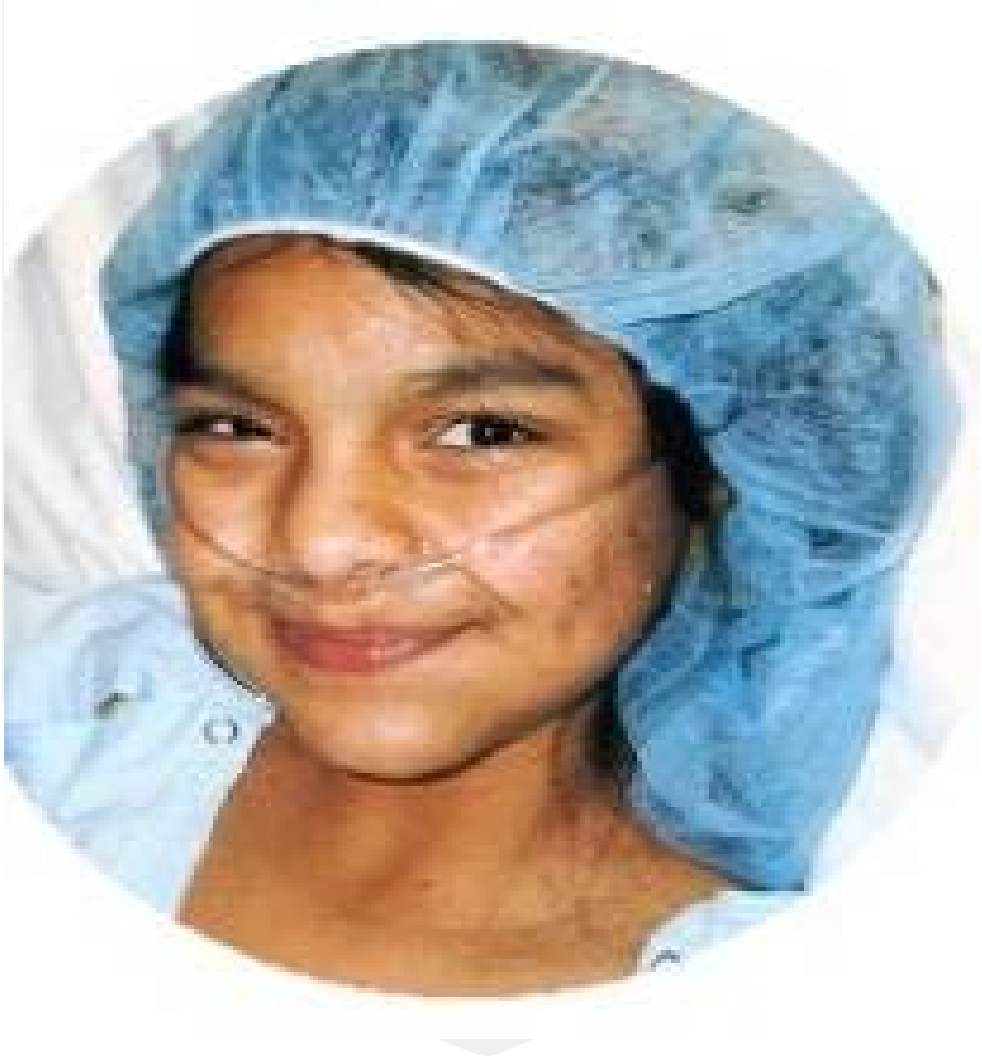
Improving Communications using Medical Team Training and Resource Management

Michael Alton MA, RN, FAEN
Duke University Health System
Assistant Patient Safety Officer

Captain Steve Powell, BA, ACHE
Healthcare Team Training, LLC

Our Catalytic Event…



Preparing the Climate

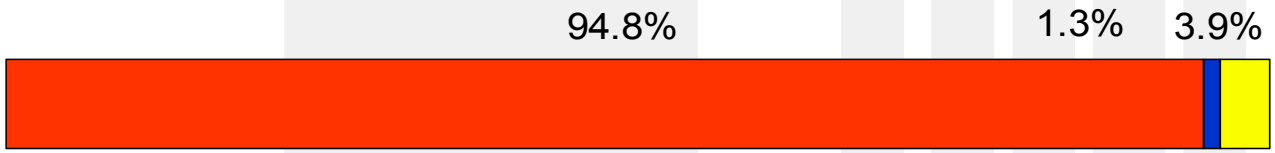
- FY06
  - Development of DUHS Patient Safety Center
  - Computerized Voluntary Reporting System
  - Core and Local Safety Teams
  - Safety Walkrounds
- FY07
  - Disclosure
  - Just Culture
  - ***Team Training (CRM)***

Establishing a Baseline

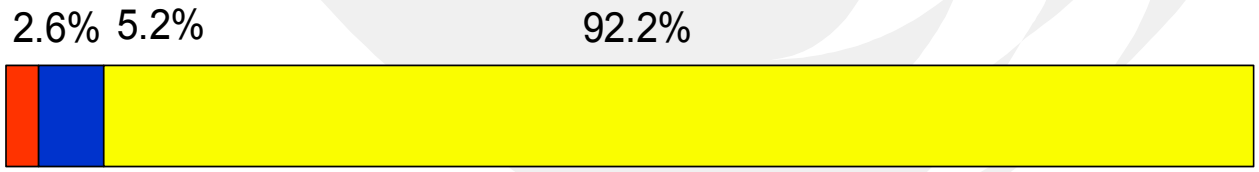
- Selected Target Areas
  - PICU
- Administered the Sexton Safety Culture Survey
  - Measures attitudes
- Conducted Real-time Observations
  - Theory espoused vs. Theory practiced
- Analyzed Reported Adverse Events
  - Reviewed safety event data base
- Analyzed Secondary Measures
  - Length of stay
  - Patient satisfaction

Teamwork

It is better to agree with other team members than to voice a different opinion (N=77): 94.8% disagree, 3.9% agree

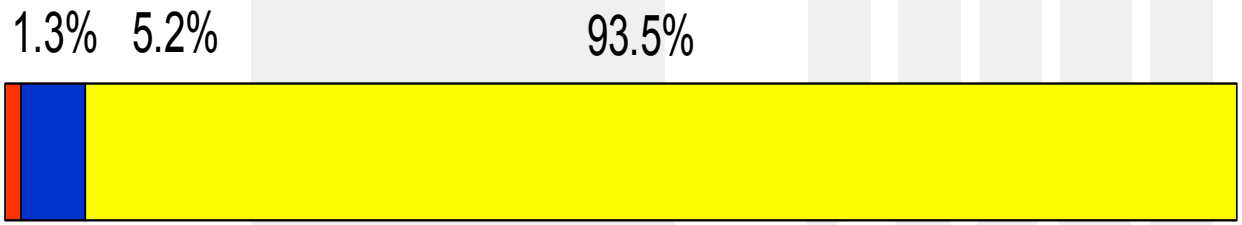


The doctor's responsibilities include coordination between his or her work team and other support teams (N=77): 92.2% agree, 2.6% disagree



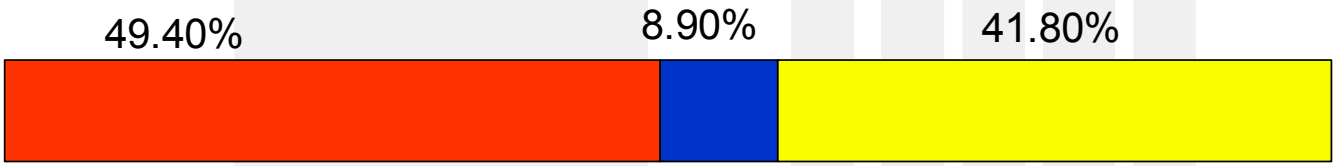
Information Sharing

A regular debriefing of procedures and decisions after a surgery or shift is an important part of developing and maintaining effective team co-ordination (N=77): 93.5% agree, 1.3% disagree.



Assertiveness

The senior person, if available, should take over and make all decisions in life-threatening emergencies (N=79): 41.8% agree, 49.4% disagree

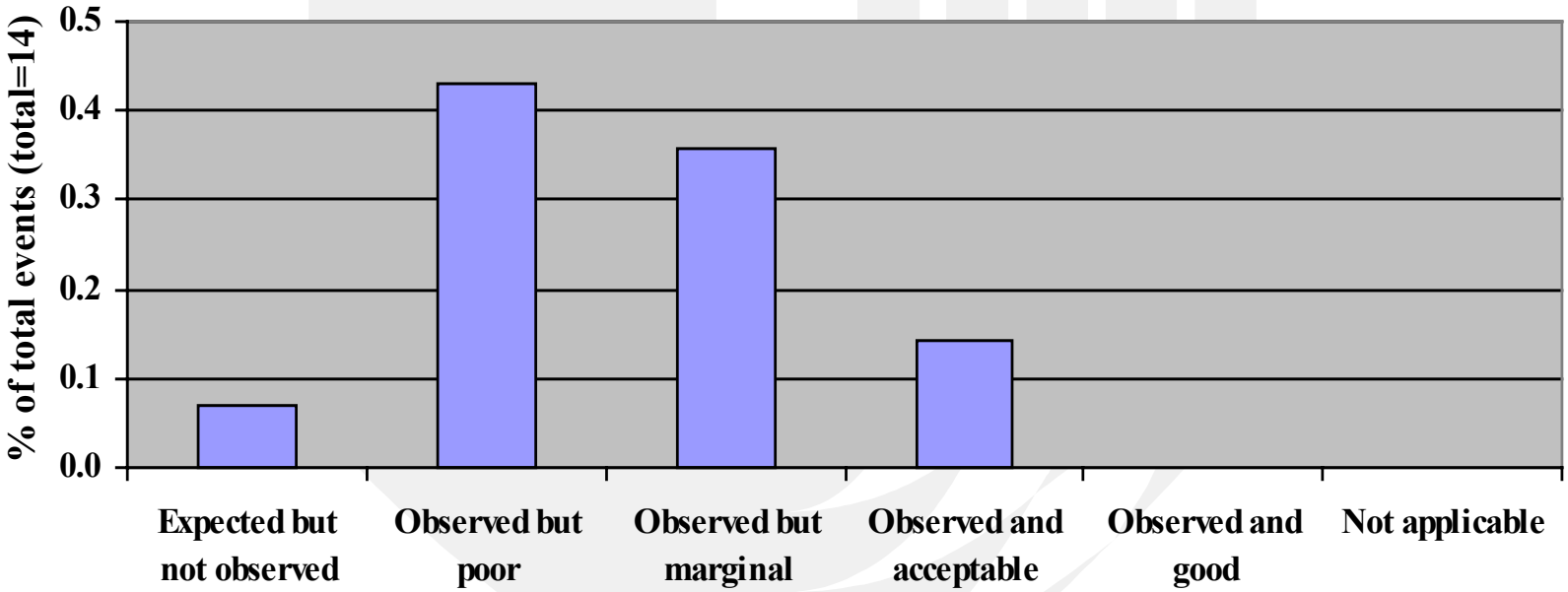


Summary: Generally agree that it is necessary to ask questions or speak up if there are perceived problems; but do not agree on who should make decisions in critical situations.

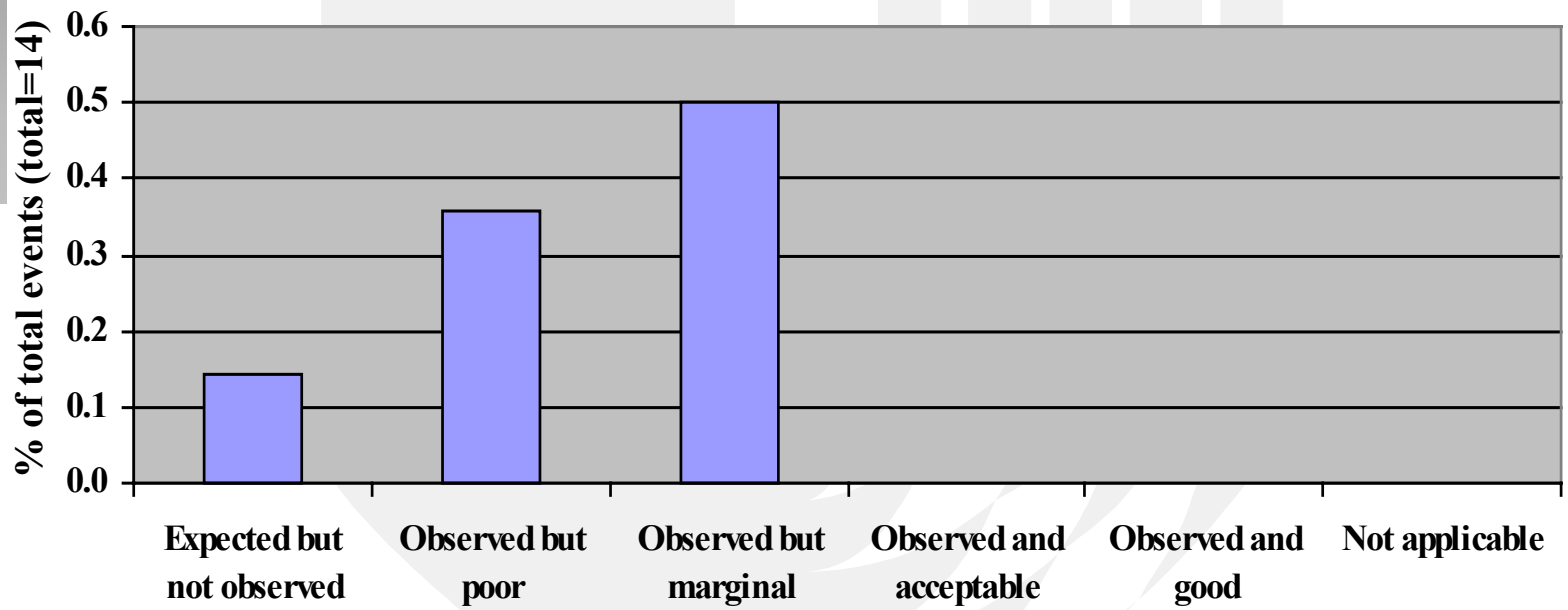
Developed an Observational Tool

Element	Behavior	0	1	2	3	4	NA
Communication	Sends and receives appropriate information						
	Verbalizes plan: States intentions, recommendations and timeframes						
	Establishes event leader (sets tone)						
Inquiry	Asks questions						
	Utilizes feedback between team members						
	Sends and receives information to/from patient/family						
	Debrief (Learns as a team)						
Teaching	Instructs as appropriate to the situation						
Vigilance/Situational Awareness	Visually scans environment						
	Cross monitors activities; Uses back-up behavior						
Adaptability	Verbalizes adjustments in plan as changes occur						
Workload Management	Secures additional resources						
	Supports others						
	Prioritizes appropriately						
Assertion	Uses appropriate critical language ("I need a little clarity")						
	Employs conflict resolution						
	Speaks up/persuades						
Overall Teamwork							
Overall Leadership							

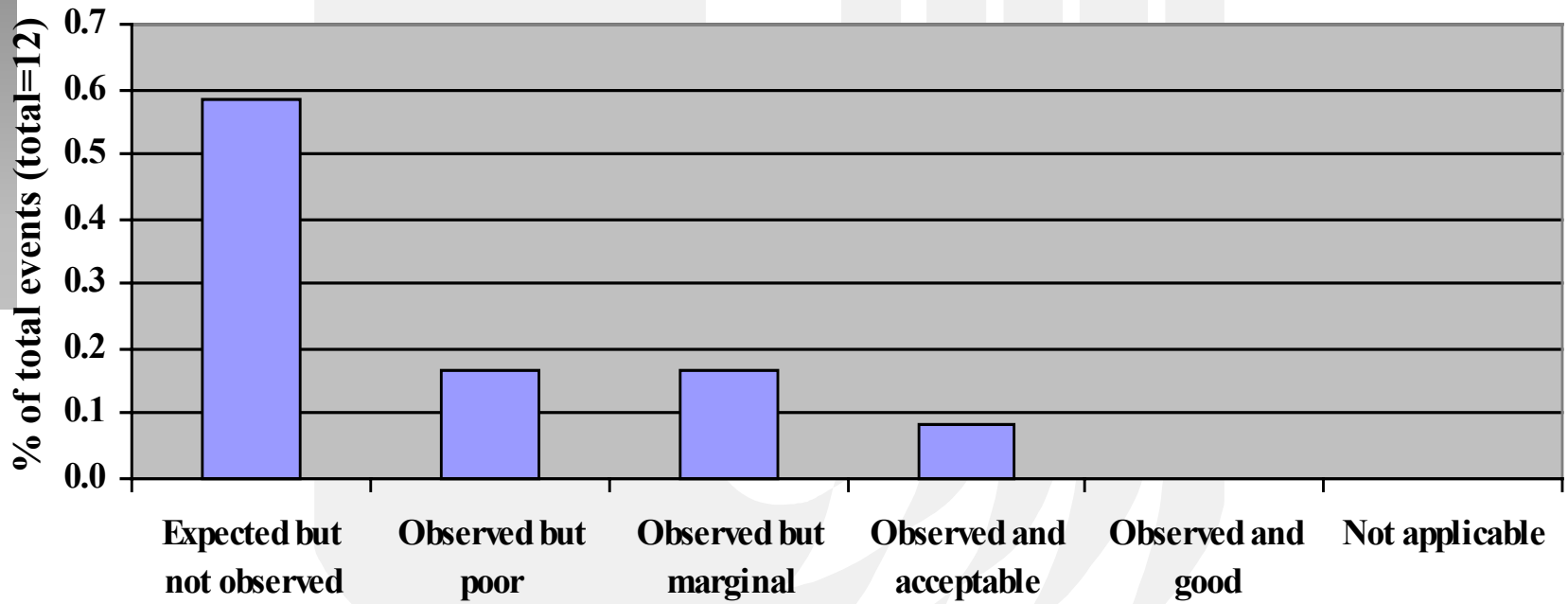
Verbalizes plan: States intentions, recommendations and timeframes



Speaks up/ Persuades



De-brief as a Team



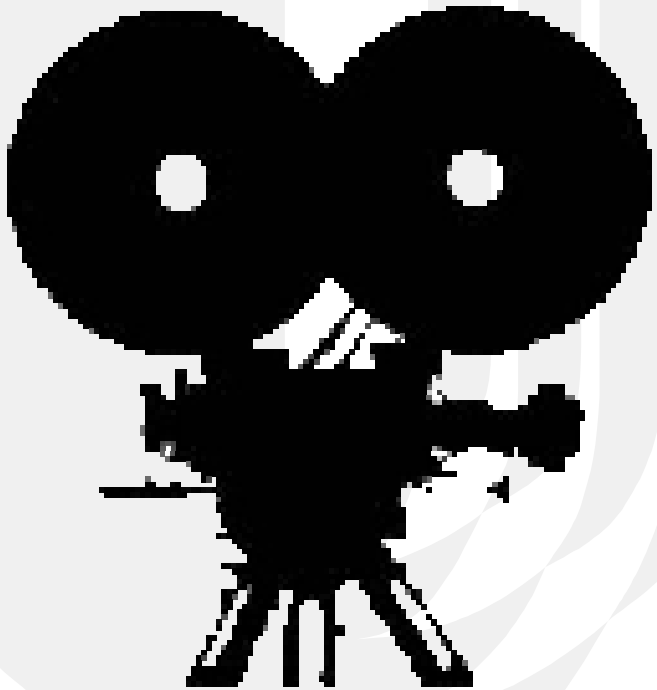
Customized Training Intervention

- Unit leaders involved from the start
- Multidisciplinary group trial
- Physician, nurse, and human factors facilitators
- Interactive session with hands-on tools
- Feedback allowed for further development
- Focused training for action at unit level

Focused Unit Training Tools

- Handoff Communication
  - SBAR for structure
- Critical Language
  - “I need a little clarity” for assertion
- “Sterile Cockpit”
  - Limit interruptions during Rounds
- Huddles for better planning
- Coaching to reinforce behaviors

Video Examples of Huddles, SBAR, Debrief and Assertion



Preliminary Results

- Huddles for Shared Mental Model
- Sterile Cockpit during Rounds
- Spread of SBAR
- Spread of Critical Language

Future Directions

- Duke-UNC Medical and Nursing Schools
- Coaching of Tools In-Unit
- System-wide deployment
- Outcome Measures

TEAM TRAINING EVALUATION BASED ON KIRKPATRICK'S FOUR-LEVEL EVALUATION MODEL

Level 4 – Results: whether the training has affected business bottom line such as increased production, improved quality, reduced accidents, decreased costs, and even higher profits or return on investment.

- Patient satisfaction survey.
- Complication rate based on AHRQ PSI.
- Length of hospital stay.
- Adverse drug events.
- Patients' claims.
- Staff satisfaction survey.
- Nurse turnover rates.

Level 3 – Behavior: whether participants change their behavior back in the workplace as a result of training.

- Observation of teamwork behaviors during routine patient care.
- Teamwork climate survey.

Level 2 – Learning: whether the training results in an increase in knowledge, skills or attitudes.

- Teamwork knowledge test.
- Survey of attitude towards teamwork.
- Survey of self-perceived communication skills.

Level 1 – Reaction: how did participants react to the training?

- Post-training reaction survey

Closing Thoughts

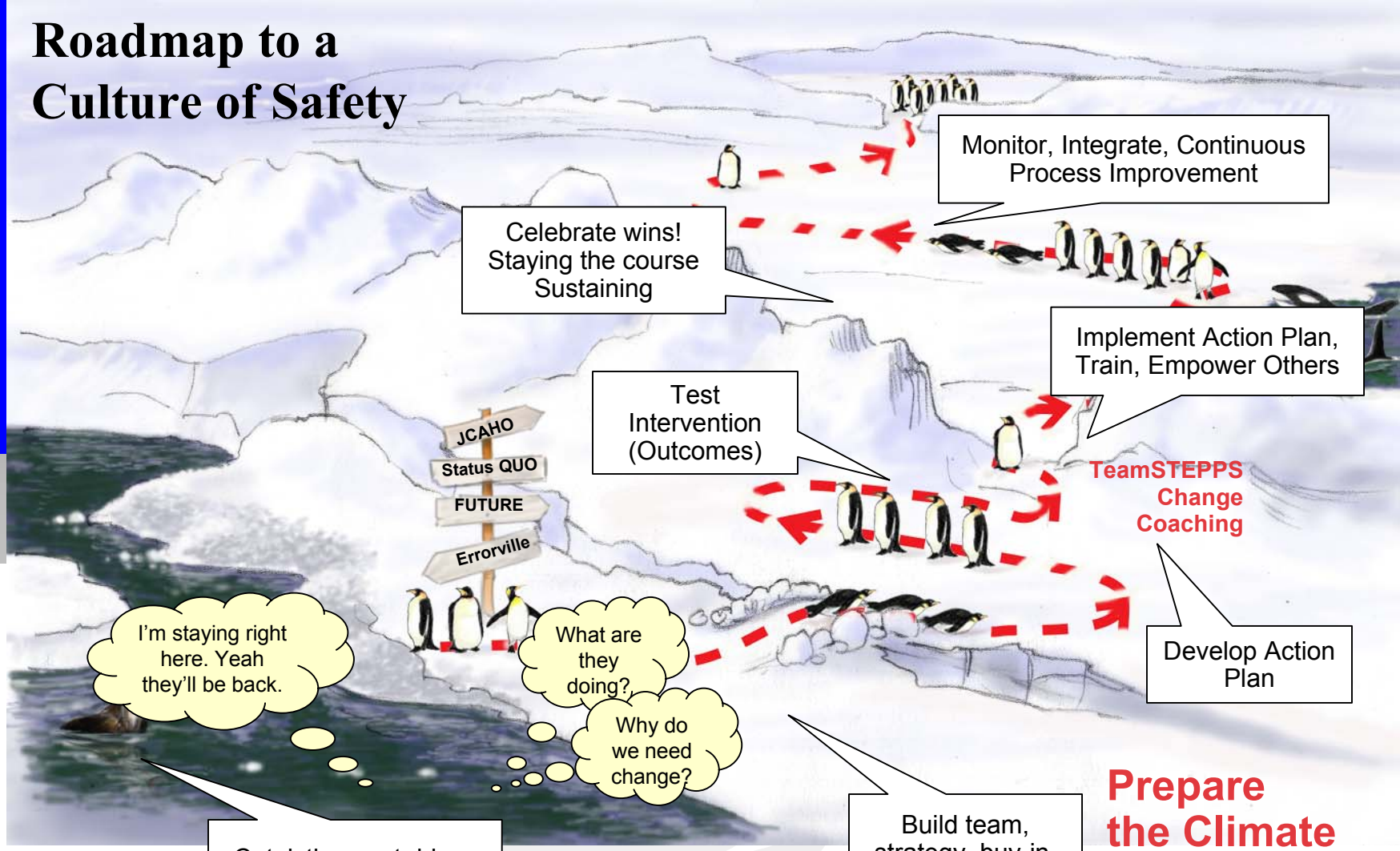
- Lessons learned
  - Need Internal Champions
  - Attach to Process Improvement
  - Coach behaviors using structured tools
  - Build consensus/buy-in/ownership
  - Repeat, reinforce and seek feedback
  - Measured dosing of new team skills

Questions?

WARNING

CHALLENGES AHEAD

Roadmap to a Culture of Safety



Source: Dr. John Kotter, PhD. Harvard Business School

Creating a Culture of Safety