# TEAMWORK & COMMUNICATION FOR PATIENT SAFETY

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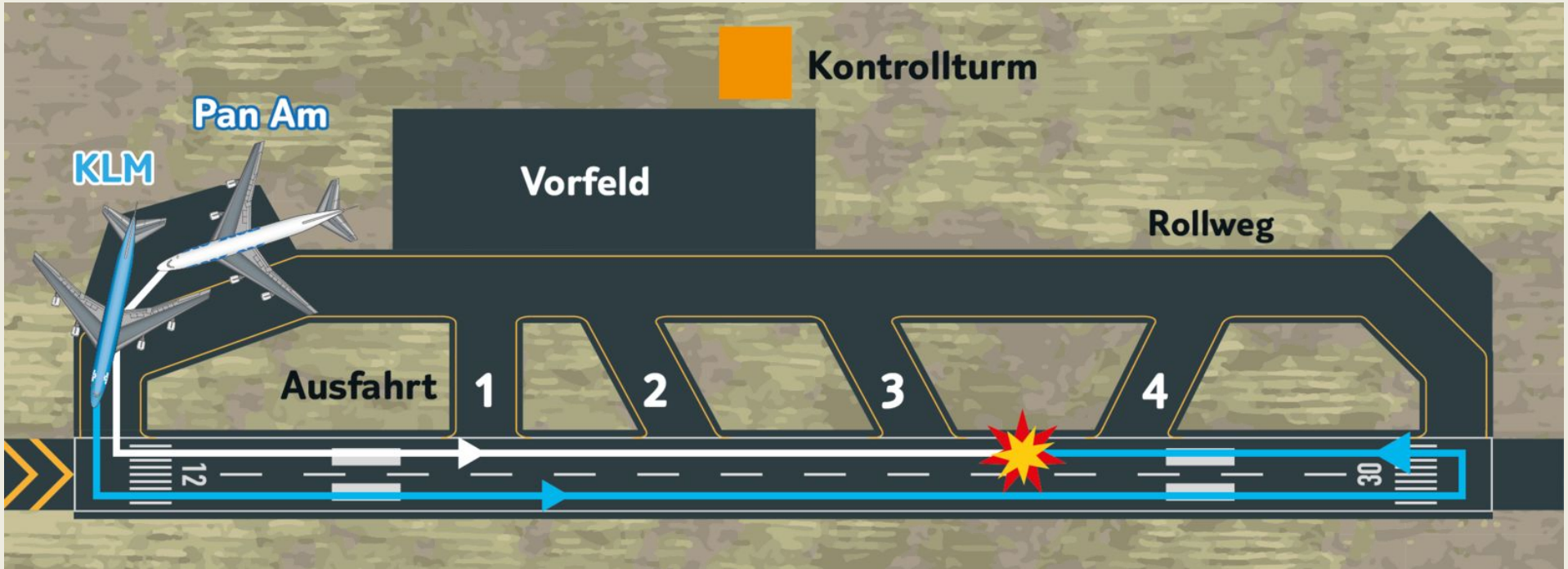
# TENERIFE AIRPORT, 1977

- Spanish Airport on Gran Canaria on diversion to neighboring Canary island of Tenerife
- Tenerife airport experience unusually high air traffic
- Patches of fog covering airfield
- Lights are out
- Pilots limited fly time, in a rush to avoid putting passengers in hotels
- Multiple large planes on small airfield requiring shuffling of planes for takeoffs

# TERERIFE CRASH

- ATC to KLM: “You are clear” to taxi to the holding point
- KLM Pilot begins to accelerate down runway
- KLM Copilot, knowing no confirmation for takeoff, to ATC: “We’re at takeoff” (plane accelerating)
- ATC: "OK, stand by for takeoff. I will call you.”
- KLM Copilot: "No, uh . . . we're still taxiing down the runway . . . ” lost from cross-radio
- PA going down runway for turnaround at 3
- ATC asks PA to report when clear and PA saying they will report when clear
- KLM flight engineer asking pilot: ”Is he not clear?”
- KLM Pilot: ”What?” > KLM engineer: “Is he not clear then?” > KLM Pilot “Oh yes”.
- KLM continues to accelerate PA sees them coming an attempts to turn
- 585 deaths ☐ “Cockpit Resource Management”



# GOALS FOR TODAY

01

Overview of team training (Crew Resource Management)

02

Discuss role of communication in patient safety

03

Review communication strategies and standardized communication tools for specific healthcare situations including patient interactions, handoffs, escalations, and speaking up.

# PATIENT SAFETY OVERVIEW

- "To Err Is Human" (1999) gave rise to modern patient safety movement
- Estimates of deaths vary, but range from tens to hundreds of thousands of Americans annually
- Errors cost tens of billions of dollars annuallys, including the expense of additional care necessitated by the errors, lost income, lost household productivity, and disability
- Errors also diminish trust in the health care system by patients
- Lead to diminished satisfaction by both patients and health professionals

# A TEAM IS...

- Any two individuals working together toward a common goal.
- All members of the group caring for a patient who are working together, including nurses, physicians, therapists, pharmacists, dieticians, case managers, and even the patient and their family.

# TEAMS & COMMUNICATION

- Health care teams that work collaboratively reduce the potential for error, resulting in better patient safety and clinical performance.
- Communication between all team members involved in patient care are essential for patient safety. From outpatient visits, hospital stays, escalations of care, handoffs in care, to discharge home, ***effective communication*** will ensure that patients receive the best care available and can participate in their care.

# EVERYONE HAS A VOICE

Authoritarian model of unquestioned leadership is dangerous.

Each member of the team is someone with important knowledge and skills,  and should be valued as such.

# COMMUNICATION IS…

- Is the lifeline of the team
- Conveys information that is timely, thorough, and concise
- Is verbal and nonverbal

# NONVERBAL COMMUNICATION

These often covey the **majority** of meaning in a message

- Facial expressions (eg, joy, anger, sadness, fear, disgust)
- Eye gaze (starting, normal, shifty/avoidant)
- Gestures (excited, inhibited)
- Tone
- Loudness

Exact same words can have opposite or varied meanings based on nuances in nonverbal communication: "We're going to have a holiday party at work!"

# FAILURES IN COMMUNICATION

- Poor communication is a major factor for errors
- According to Joint Commission on Accreditation of Healthcare Organizations
  - Communication failure is one of the **top 3** root causes of sentinel events
  - Communication failures have been implicated as the root causes of **greater than 60%** of sentinel events
- Most errors linked to communication failures are preventable!

# NURSE VS DOCTOR ON SAME EVENT

- Combative pt: nurses report the struggle, docs report the med and subsequent management
- Fall: nurses report the narrative, docs report need for additional imaging and management of other condition
- Lab error: nurses report narrative (how it happened, what it was, how pt felt, team notified), docs report management of the level and concern for wrong number on other pt

# COMMUNICATION TRAINING

- Can overcome barriers including fear of bothering, unsure what info is needed, differences in training styles
- Set expectations
- Helps consistency
- Familiarization with process improves time needed to transmit information

# CREW RESOURCE MANAGEMENT

Crew resource management emphasizes **teamwork**, recognizing adverse situations (**situational awareness**) and **communication.**

- Before an encounter, discuss and identify potential issues; creates "shared mental model" ☐
- Identify all crew members, roles, and goals ☐
  - *Teams who have brief introduction prior to activity perform better!*
- Open dialogue during event ☐
- Debrief discussing what went well or not and learning from errors

# SITUATIONAL AWARENESS = KNOWING WHAT IS HAPPENING

- Perception: awareness of environment, time, supplies, staff
- Comprehension: deviation from normal, implications
- Projection:  anticipate responses

# CRM EXAMPLES IN THE HOSPITAL

- Before operation, a surgeon might briefly review plan, discuss the pt risk factors and mitigation strategies (hemophilac but got factor prior to surgery and have extra blood available for the pt and will plan on checking extra labs later).

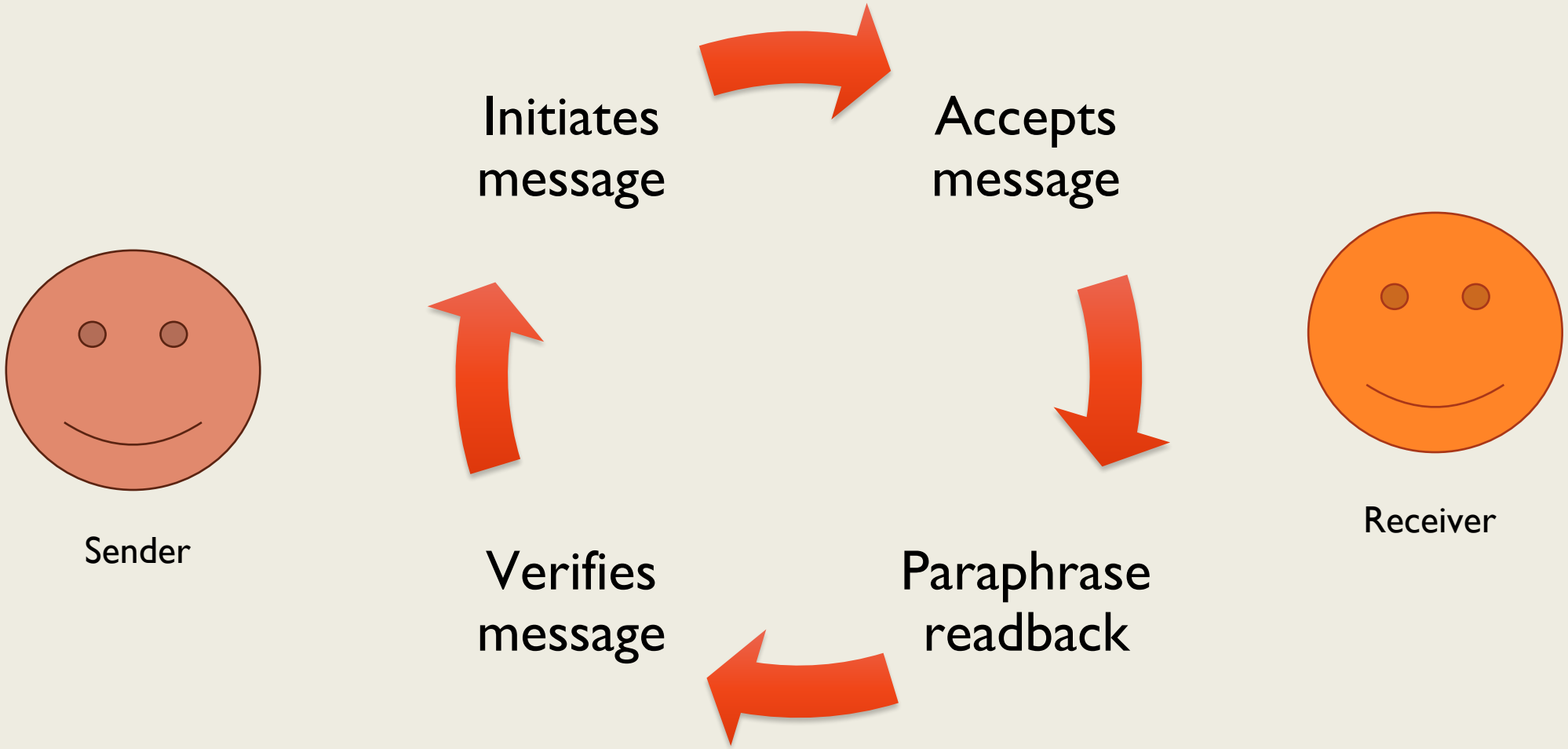
- Other examples: clinic during flu season, ICU during covid, any other scenario in your microsystem and where you prepare to meet the day's challenges

# COMMUNICATION STRATEGIES

# MINDFUL, ACTIVE LISTENING

- concentrates on the message
- is aware of non-verbal communication
- looks for incongruence between what is being said and non-verbal cues
- asks clarifying questions
- *summarizes at the end to ensure mutual understanding, which brings us to…*

# CLOSED LOOP COMMUNICATION



# CLOSED LOOP COMMUNICATION: FASTFOOD VERSION

- I order the cheeseburger extra pickles and milkshake.
- They repeat back my order.
- I confirm or clarify the order.

# STRUCTURED COMMUNICATION TOOLS

- Healthcare workers to patients: AIDET
- Some handoffs, Escalation of care: SBAR
- Handoffs: “I PASS the BATON” and I-PASS
- Speaking up:
  - CRM
  - CUS
  - Two challenge

# PATIENT INTERACTIONS: AIDET

- **Acknowledge** - Great the patient by name and acknowledge family members or visitors in the room. Eye contact. Smile.
- **Introduce** – Introduce yourself by name, skill set, professional certification, experience and their role in the patient's care.
- **Duration** – Describe estimated times for next steps of the visit or procedure. If unknown, reassure that you will update on progress.
- **Explain** - explain what they are going to do, how they are going to do it, and why they are doing it as well as answer any questions the patient may have.
- **Thank** – Summarize visit. Thank the patient and/or family for their time and cooperation.

*Use interpreter if needed.*

# HANDOFFS/ESCALATION: SBAR

Communication across disciplines is challenging, as each has its own language and methods

Decreased time for nurse report times and interdisciplinary rounds

Newer nurses report more like experienced nurses

- **Situation** – What is happening?
- **Background** – What is the clinical background?
- **Assessment** – What do I think the problem is?
- **Recommendation** – What do I think should happen now?

"I'm calling about patient in 536, his IV infiltrated. "
Or "we've already drawn X cc of blood."

VS

"I'm the nurse taking care of baby X who is here for febrile neonate workup. His IV infiltrated and he was supposed to get an antibiotic 30 minutes ago. I think we should call SWAT to replace his IV because he was a very difficult stick." Or, "we have almost reached the limit of blood draws for today, we should do the send-out labs tomorrow."

# HANDOFFS: I PASS THE BATON

| | | |
|---|---|---|
| I | Introduction | Introduce yourself and your role |
| P | Patient/resident | Patient identifiers, age, sex, location. |
| A | Assessment | Chief complaint, vital signs, symptoms, diagnosis. |
| S | Situation | Current status, circumstances, including code status, level of (un)certainty, recent changes, response treatment |
| S | SAFETY concerns | Critical lab values/reports, socioeconomic factors, allergies, alerts (falls, isolation, etc.). |
| THE | | |
| B | Background | Comorbidities, previous episodes, medications, family history. |
| A | Actions | What actions were taken or are required? Provide brief rationale. |
| T | Timing | Level of urgency and explicit timing and prioritization of actions. |
| O | Ownership | Who responsible (person/team) patient/family? |
| N | Next | What will happen next? Anticipated changes? What is the plan? Are there contingency plans?" |

# HANDOFFS: I-PASS

| | | |
|---|---|---|
| I | Illness Severity | Stable, "watcher", unstable |
| P | Patient Summary | Summary statement, events leading to admission, hospital course, ongoign assessment and plan |
| A | Action List | To do list, timeline and ownership |
| S | Situational awareness | Know what is going on and what to do for contingencies |
| S | Synthesis by receiver | Receiver summarizes what is heard, asks questions, restats key action iteams |

# SPEAKING UP STRATEGIES

Good leaders will do their best to establish a predictable invironment that responds dynamically to changing clinical situations.

Team members at all levels must always feel their input is **valued and expected**, especially in situations that threaten patient safety.

  - Team members must have an open platform to discuss opinions or concerns without punishment or humiliation. (“Deference to expertise!”)

- CUS language
- Two challenge rule

# EMPOWER THE TEAM

- Landau & Chisholm (1995) report this anecdote:  A seaman on nuclear aircraft carrier discovered during a combat exercise that he'd lost a tool on the deck. He knew that the tool could cause a catastrophe if it were sucked into a jet engine. On the other hand, if he were to report it, the entire expensive exercise would be sacked, and a dozen planes in the air would have to be redirected. He reported anyway. The crew then scour the deck for the tool and it was found. Rather than being punished for his error, the seaman was commended by his commanding officer in a formal ceremony for his bravery in reporting.
- Lidocaine & ketamine vials

# SPEAKING UP

"Mrs. Smith's blood pressure is 105/84".

Remove ambiguity.

Give context to highlight importance of concern.

Be respectful but persistent.

Pay attention to nonverbal cues.

Ask for clarification.

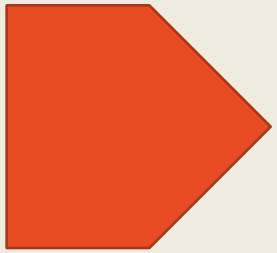
Be an ACTIVE listener.

# CRM ADVOCACY AND INQUIRY

- **Opening:** Hey Doc!
- **State your concern:** I'm worried about Mrs. Smith's blood pressure.
- **State the problem:** It has continued to drop and also her heart rate is going up. I'm worried she is septic.
- **State a solution:** I think we should get cultures and start antibiotics.
- **Obtain agreement:** Does that sounds good to you?

# “CUS” LANGUAGE

- Concern
- Uncomfortable
- Safety issue



“Stop the line”

TeamSTEPPS (Strategies & Tools to Enhance Performance & Patient Safety) is free training program from Agency for Health Care Research and Quality

# TWO CHALLENGE RULE FOR SAFETY

- It is every team member's responsibility to assertively voice concern at least ***two times*** to ensure it has been heard.
- The team member being challenged ***must acknowledge*** the concern.
- If the outcome is still not acceptable, take a stronger course of action, go up chain of command.

# REVISITING TENERIFE

- What if…..
  - Pilot had waited for confirmation approval for takeoff?
  - Copilot had spoken up?
  - Engineer had spoken up?

# CASES

- Young child in the Emergency Department has a Ventriculo-Peritoneal shunt to drain excess fluid from around his brain into his abdomen. These patients are at risk for shunt infection or failure. The ED contacts a neurosurgeon about the patient who is having fever and headaches. However, the head imaging shows no signs of shunt malfunction so neurosurgery says they do not need to see the patient. The ED physician then tells the family this and than once some other tests have returned, they will likely go home. In the meantime, the neurosurgeon speaks with a colleague, then decides to obtain cultures from the patient's shunt and admit him to their service, but doesn't tell the ED. The ED physician discovers this while going in the room to update the family on the lab results and discharge the patient.
- Doctor orders a medication. Nurse, in another area of the unit, sees the order pop up, gets the medicine, and gives it to the patient. Then the nurse returns to the desk to chart it and sees that the physician has cancelled the order.

# REVIEW

- Everyone who participates in patient care is on the team.
- Foster a culture that respects all team members as valued participants, including patients!
- Remember to be aware of non-verbal cues both given and received.
- Poor communication amongst team members is a leading cause of medical errors and dissatisfaction among providers and patients.
- Standardized communication tools like SBAR, I-PASS / I PASS the BATON, and AIDET can help improve the quality and efficiency of communication among team members.
- Techniques of active listening, closed loop communication, and speaking up with CUS language and two-challenge rule can improve communication and avoid or mitigate harm to patients.

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