

# The Role of Teamwork in a Culture of Patient Safety

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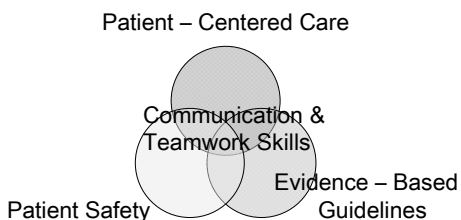
Resident & Patient Safety Learning Collaborative  
March 26, 2009

## Objectives

- Identify barriers to effective teamwork
- Differentiate multidisciplinary group care from interdisciplinary team care
- Identify four skills within the TeamSTEPPS™ curriculum needed to function effectively in a healthcare team
- Describe how practices that support a Just Culture and a Teamwork Culture build a foundation of trust in a culture of safety
- Plan to manage disruptive behavior as a practice that supports Just Culture and Flexible Teamwork Culture

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## A Framework for Quality Care



Adapted from Lyons & Coleman (In Press).

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## Six Elements of a Team

- Complementary skills
- Interdependent tasks
- Clear role expectations
- Common purpose
- Performance goals
- Mutual accountability



Baker, Day, & Salas (2006)  
Katzenbach & Smith (2005)  
Rubin & Beckhard (1972)

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## Groups vs. Teams

### Working Group

- Designated leader
- Individual accountability
- Individual work products
- Efficient meetings
- Indirect measures of performance
- Discusses, decides, delegates

### Team

- Share leadership roles
- Mutual accountability
- Collective work products
- Problem-solving meetings
- Direct measures of performance
- Discusses, decides, works together

Essence of a team is common commitment

Katzenbach & Smith (2005), Crooks & Geldmacher (2004)

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## Why do we need teamwork?

- 44,000 – 98,000 people die each year due to medical errors in hospitals Institute of Medicine (2000)

- Ineffective communication contributes to sentinel events

<http://www.jointcommission.org/SentinelEvents/Statistics/>



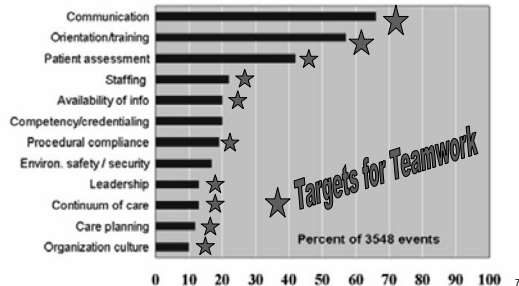
“The greatest problem in communication is the illusion that it has been accomplished.”

--George Bernard Shaw

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## Why do we need teamwork?

Root Causes of Sentinel Events  
<http://www.jointcommission.org/SentinelEvents/Statistics/>  
 (All categories; 1995-2005)



## Barriers to Team Effectiveness

BARRIERS	TOOLS and STRATEGIES	OUTCOMES
Inconsistency in Team Membership	Brief	Shared Mental Model
Lack of Time	Huddle	
Lack of Information Sharing	Debrief	Adaptability
Hierarchy	STEP	
Defensiveness	Cross Monitoring	Team Orientation
Conventional Thinking	Feedback	
Complacency	Advocacy and Assertion	Mutual Trust
Varying Communication Styles	Two-Challenge Rule	
Conflict	CUS	Team Performance
Lack of Coordination and Follow-Up	DESC Script	
Distractions	Collaboration	<i>Patient Safety!!</i>
Fatigue	SBAR	
Workload	Call-Out	
Misinterpretation of Cues	Check-Back	
Lack of Role Clarity	Handoff	

## Why do we need teamwork?

- Care transitions—actions performed by providers to ensure care is continuous and coordinated across levels and settings of care



For Every 1,000 persons age 65

- 400 amb visits
- 300 visits to ED
- 200 hospital admits
- 46 SNF admits
- 106 home care admits

Coleman, EA. Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. J Am Geriatr Soc. 2003, 51:549-555.

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## Why do we need teamwork?

- Barriers exist that prevent effective transitions
  - System
    - Lack of formal relationships between settings
    - Lack of financial incentives to promote transitional care
    - No formal quality measures for care transitions
    - Lack of information systems (HIPAA??)
  - Provider
    - Proliferation of specialists, hospitalists...no one clinician in charge
    - Nursing shortages prevent follow up to incomplete DCs
    - No formal training in transitional care...verbal communication rare
    - Case managers typically setting specific
  - Patient
    - Do not appreciate the problem until too late
    - Do not feel empowered to express preferences, intimidated

Coleman EA. (2003)

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## Why do we need teamwork?

- Uncoordinated care transitions result in
  - Adverse drug events Gurwitz et al. (2003)
  - Missed and delayed diagnoses Gahndi et al. (2006)
  - Delays in reviewing test results Poon et al. (2004)
  - Missing clinical information Smith et al. (2005)
  - What else from your experience?
- Perceptions of the cause differ
  - Providers perceive patients as nonadherent Poon et al. (2004)
  - Patients perceive that care is poorly coordinated Weinberg et al. (2007)

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## Effective Transitions Require Teamwork

- Communication between sending and receiving clinicians:
  - Common plan of care
  - Summary of care provided by sending institution
  - Patient's goals and preferences (including adv. directives)
  - Updated list of problems, baseline status, meds and allergies
  - Contact information for patient's caregiver(s) and PCP
- Preparation of patient, caregiver for what to expect next
- Reconciliation of medications
- Follow-up plan for tests and appointments
- Explicit discussion regarding red flags to monitor that may indicate that condition has worsened and the name and phone number of who to contact if this occurs

Coleman EA. (2003)

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## 2008 Joint Commission Communication Related NPSGs

- Goal 2 Improve effectiveness of communication among caregivers
  - 2A Read-Back
  - 2B Standardize a list of abbreviations
  - 2C Timeliness of reporting critical test results
  - 2E Standardized handoffs
- Goal 8 Accurately and completely reconcile medications and other treatments across the continuum of care
- Goal 13 Encourage active involvement of patients and their families in the patient's care
- Goal 16 Improve recognition and response to changes in a patient's condition
- July 9, 2008 Sentinel Event Alert: Intimidating and disruptive behaviors can foster medical errors

[http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea\\_40.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm) 13

## Interdisciplinary Teams in Healthcare

- Teamwork in healthcare
  - Effective team performance is a key principle of safe care
  - IOM: "People make fewer errors when they work in teams."
- Barriers to effective teams in healthcare
  - Training occurs in separate disciplines
  - Team members receive little team training
  - Traditions of professional autonomy & deference to authority

Institute of Medicine (2000)

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## Teamwork—Essential Component of Patient-Centered, Safe Care

- Teams have two inter-related tasks
  - Clinical task competence
  - Team behavior competence
- Competence in teamwork
  - Knowledge
  - Skills
  - Attitudes

Rubin & Beckhard (1972)

Baker, Day, & Salas (2006)

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## What comprises team performance?

### TeamSTEPPS

Team Strategies & Tools to Enhance Performance & Patient Safety

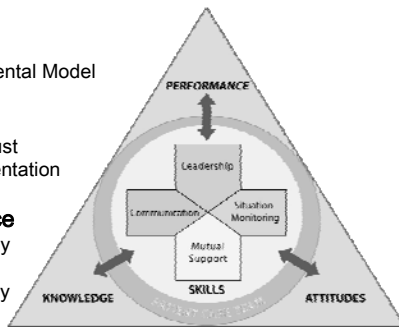
<http://www.ahrq.gov/qual/teamsteps/>



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## Outcomes of Team Competencies

- **Knowledge**
  - Shared Mental Model
- **Attitudes**
  - Mutual Trust
  - Team Orientation
- **Performance**
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety

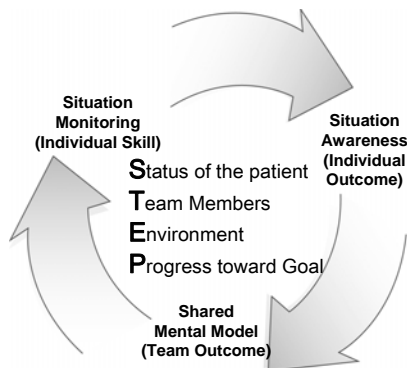


<http://teamsteps.ahrq.gov/abouttoolsmaterials.htm> 17

## Skill Overview: Leadership

- Organize the team
  - set clear goals & delegate tasks
  - manage resources
- Ensure team members share information
  - Formal team meetings & informal exchange sessions
  - Make decisions through collective input
  - Empower team members to speak up
- Resolve conflict
- Actively model and facilitate good teamwork
- May be designated or situational

## Skill Overview: Situation Monitoring



## Skill Overview: Mutual Support

- “Back up behavior” to prevent work overload
  - Task assistance is sought and offered
  - Provide effective feedback: Timely, Respectful, Specific, Directed towards improvement, Considerate
- Advocate for the patient through conflict resolution
  - “CUS” to solve information conflicts
    - I’m Concerned ( I need clarity)
    - I’m Uncomfortable
    - Consequences in terms of patient Safety
  - DESC Script to solve personal conflicts
    - Describe the behavior
    - Express how the situation makes you feel
    - Suggest alternatives
    - Consequences stated in terms of patient safety

## Skill Overview: Communication

- Exchange of information between sender & receiver
- Effective communication
  - Brief
  - Clear
  - Timely
  - Complete: Know the plan, share the plan, review risk

Salisbury & Hohenhaus (2008)
- Three elements account for meaning of message
  - Words 7% of meaning
  - Tone of voice 38% of meaning
  - Body language 55% of meaning

## Communication Skills

### SBAR

- Situation – what is going on with the pt.
- Background – clinical background
- Assessment – what do I think is the problem
- Recommendation – how can we correct it

- Call-out—informs all team members simultaneously
- Check-back—Close the loop as receiver accepts a message, sender double-checks to ensure message was received

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## Communication Skills

- Handoff—transfer of information (along with authority and responsibility) during transitions in care; must include opportunity to ask questions, clarify, and confirm
- Introduction
- Patient
- Assessment
- Situation
- Safety Concerns
- Background
- Actions
- Timing
- Ownership
- Next



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## TeamSTEPPS Reference

To learn more about the national implementation of TeamSTEPPS and to order the curriculum including power point slides, videos, and pocket guide with tools, go to the Agency for Healthcare Research and Quality site at

<http://teamstepps.ahrq.gov/abouttoolsmaterials.htm>

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## Components of Safety Culture

A culture of safety is informed. It never forgets to be afraid...

Reason, J. (1997). *Managing the Risks of Organizational Accidents*. Hampshire, England: Ashgate Publishing Limited.

Battles et al. (2006). Sensemaking of patient safety risks and hazards. *HSR*, 41(4 Pt 2), 1555-1575.

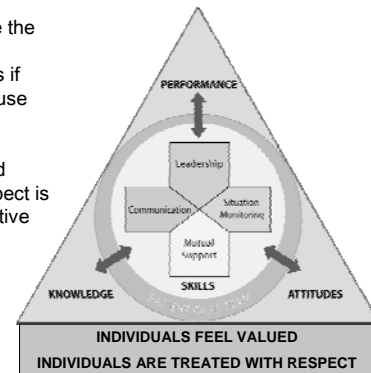


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## Individuals Operate within Teams

We must acknowledge the impact of disruptive behavior on individuals if they are to effectively use TeamSTEPPS skills.

Valuing individuals and treating them with respect is the foundation of effective communication and teamwork.



## Disruptive Behavior

Joint Commission Sentinel Event Alert

WEDNESDAY, July 9, 2008

"Intimidating and disruptive behaviors can . . . foster medical errors, contribute to poor patient satisfaction and preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments.

Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment.

To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team."

[http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea\\_40.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm)

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## Definition of Disruptive Behavior

Disruptive behavior is any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical or sexual harassment. Disruptive behavior causes strong psychological and emotional feelings, which can adversely affect patient care.

Rosenstein A, O'Daniel M. (2008). Managing disruptive physician behavior: Impact on staff relationships. *Neurology*, 70, 1564-1570.

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## Disruptive Behavior

- Old frame of reference
  - Tolerate the behavior as a way of doing business
  - Shrug off the problem; minor occurrence with no ill effects to patients or staff
- New frame of reference
  - Disruptive behaviors have profound effect on patient safety and quality of care
  - Not unique to physicians or healthcare
  - Consequences permeate the organization
    - Affect staff morale, patient and family
    - Community perceptions and hospital reputation.
  - Hospitals can no longer take a passive approach to disruptive behaviors

Rosenstein & O'Daniel (2008). *Neurology*, 70, 1564-1570.

## *Address Disruptive Behavior to Support Just Culture*

- Raise awareness – survey
- Develop policies/procedures
  - Code of behavior
  - Confidential reporting system
  - Enforcement—interdisciplinary staff relations committee
  - Follow-up and feedback to reporters and all staff
- Education
  - Link behavior to adverse events
  - Communication and teamwork—TeamSTEPPS

Rosenstein A, O'Daniel M. (2008). Managing disruptive physician behavior: Impact on staff relationships. *Neurology*, 70, 1564-1570.

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## The Importance of Teams in Organizational Learning

“Teams are the fundamental learning units in modern organizations. Unless teams can learn, organizations cannot learn.”

Peter Senge (1990). *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday Currency, p. 10.

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