AHA Team Training

Simple STEPPS for Engaging Physicians Partners to Sustain Your Safety Culture

March 10, 2021

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Upcoming Team Training Events

**Webinars**
April 14th, 12pm CT/1pm ET – Design Thinking for Human Centered Health Care, [Register here!](#)

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Our Core Philosophy:

Help organizations reduce variation in knowledge, judgement, clinical practice and outcomes

Personalize learning to address an individual’s gap in practice or knowledge, while respecting established proficiency

Empower organizations on their journey to high reliability to improve the healthcare experience for all

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Assess Proficiency → Measure Learning → Identify Risk

“Relias’ performance management platform has played a crucial role in our progress and pursuit of better health, better care and lower cost. Our success is almost single-handedly the result of our wide-scale focus on the elimination of irrational variation, and the Relias technology is our empirical platform and partner in that pursuit.”

-St. Luke’s Health System
Today’s Presenter

Jason Cheng D. O.
Safety and Human Factors
Education Co-Chair
Kaiser Permanente Southern
California Region, Department of
Anesthesiology
Today’s Objectives

Participants will..

- Apply change management approaches to building a team of physician safety champions
- Reframe discussions around errors to create resilience and a culture of learning
- Understand the significance of cognitive bias, and how to harness an improved understanding of cognitive bias to improve both safety and quality
- Empower physicians to embrace the benefits of shifting from clinical leader to being a team leader
23,500 Physicians

64,000 Nurses

12 Million Members
Focus on the few...maybe even “the one”
Not these few...
Roadmap to a Culture of Safety

Celebrate Wins! Staying the Course Sustaining

Monitor, Integrate, Continuous Process Improvement

Implement Action Plan, Train, Empower Others

Test Intervention (Outcomes)

TeamSTEPPS Change Coaching

Develop Action Plan

Prepare the Climate

Catalytic Event Drives Need For Change

Build Team, Strategy, Buy-In, Establish Goals
Share the story
• Enterprise-wide biweekly broadcast focused on sharing incident and learnings

• Comprehensive RCA2 (CSA—comprehensive systems analysis) presentation with Cause maps stemming from “5 whys”

• Focus of presentation with discussion of Just Culture Algorithm to provide a balanced accountability between individual and systems

• Second Victim
SBAR – Patient Safety Huddle Call

2/8/19 (WRONG SITE SURGERY)

S – A 61 year old male patient had a surgical excision of the wrong lesion on his back performed in General Surgery clinic. On 11/14/17 a procedure was done to remove a lesion for Melanoma in situ.

B – The patient had multiple lesions on his back and the lesion that was to be excised on the day of surgery was misidentified. The patient and a family member were part of the procedure verification and they had pointed to the incorrect lesion. Once this was identified as the incorrect lesion, a second surgery was scheduled and the correct lesion was removed.

A – At the time of the first surgery the General Surgery clinic did not have a standardized process that included Universal Protocol components. The picture taken in Dermatology of the lesion was not part of the verification process and there was reliance on the patient to identify the correct lesion.

R – Universal protocol and all of its components will be used in clinic areas. This will include the site marking, chart review and review of the informed consent prior to the signed patient consent form.

**ACTIONS FROM CSA:**

<table>
<thead>
<tr>
<th>Area of Implementation</th>
<th>Action to Be Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Area</td>
<td>Photo verification will take place as part of the surgical briefing. (Marking)?</td>
</tr>
<tr>
<td></td>
<td>The member will be part of the briefing, if any discrepancy between what the member shares and what the chart signifies, the procedure will stop until the site is validated.</td>
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Nonverbal communication can be just as powerful as verbal communication. When someone on the team doesn't speak up, what effect does the leadership and culture on the entire team at that moment? What potential consequences might there be on the team's perception of speaking up after an episode such as this?

Nurse stopped the case from moving forward until the right process was done.

00:22

Feel free to answer the prompts in the chat.

not inviting

opposite of speak up culture

rushed

Devalues time out process

Recoding has started
Build a system of feedback from your audience

1. It is easy to SPEAK UP about errors, mistakes, or ethical concerns.
   - Strongly Disagree: 0
   - Disagree: 2
   - Neutral: 3
   - Agree: 21
   - Strongly agree: 12

2. The CULTURE in my dept makes it EASY TO LEARN from my errors or errors of others.
   - Strongly Disagree: 0
   - Disagree: 0
   - Neutral: 2
   - Agree: 20
   - Strongly agree: 15

3. We communicate openly and honestly with each other, even when our opinions differ.
   - Strongly Disagree: 0
   - Disagree: 1
   - Neutral: 4
   - Agree: 22
   - Strongly agree: 10

4. The people I work with treat each other with respect despite differences.
   - Strongly Disagree: 0
   - Disagree: 0
   - Neutral: 0
   - Agree: 16
   - Strongly agree: 21
Data helps support your story
Reason with Swiss Cheese...
“Health care training, particularly that of doctors, is predicated on a belief in trained perfectability”

“Medical errors are marginalized and stigmatized”

“They are, by and large (in stark contrast to those in aviation and many other domains) equated to incompetence.”
Be aware of what our instinctive behaviors!

To make a mistake is human, but to blame it on someone else, that's even more human.

SAY NOTHING
THEY'LL BLAME THE DOG
Institute of Medicine (IOM) in 1999 called for a national effort to make health care safer.

United States at least 44,000 people, and perhaps as many as 98,000 people die for preventable medical errors.

Cost of medical errors claims: between $17 billion and $29 billion per year in hospitals nationwide.

More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.
LATENT SAFETY FACTORS

- Culture
- Policies
- Processes
- Practice

Checklists, Training, Onboarding, Competencies

Psychological Safety, Accountability

Risk

Bad Events
Active Failures--Practice Slice

Cross-monitoring, HardStops

Workflow Variations

Communication

Inconsistent training

Situational "Awareness" → Closed Loop Communication

Standardization, Briefings/Huddles/Debriefings

Interval Training, simulation-video based, in-person, hybrid
Opportunities—Root cause analysis, Case reports, Quality improvement, journal club, etc.

CLASSIFICATION OF ERRORS

UNSAFE ACT

- UNINTENDED ACTION
  - BASIC ERROR TYPES
    - Attentional failures
      - Intrusion
      - Omission
      - Mistiming
      - Etc.
    - Memory failures
      - Forgetting
      - Omission
      - Place-losing
    - Rule-based
      - Misapplication of good rule
      - Application of bad rule
    - Knowledge-based
      - Many variables
      - Untested Process
    - Routine violations
      - Exceptional violations
    - Acts of sabotage

INTENDED ACTION

SLIP

LAPSE

MISTAKE

VIOLATION

Taken from 'Human Error', James Reason (1990, 2009), p207
Identify near misses and promote good catches
FROM ERROR TO RESILIENCE

Model LEADERSHIP

Cultivates COMMUNICATION

Enhance WORKFLOWS/Polices

GOOD CATCHES

LEARNING CULTURE
Taking a deeper dive...
Situational Awareness starts with our OWN awareness

“metacognition lies at the root of all learning”

“...self-knowledge, awareness of how and why we think as we do, and the ability to adapt and learn, are critical to our survival as individuals...”

- James Zull (2011) From Brain to Mind: Using Neuroscience to Guide Change in Education
Cognitive Processes in Anesthesiology Decision Making

Marjorie Podraza Stiegler, M.D., Avery Tung, M.D., F.C.C.M.

ABSTRACT

The quality and safety of health care are under increasing scrutiny. Recent studies suggest that medical errors, practice variability, and guideline noncompliance are common, and that cognitive error contributes significantly to delayed or incorrect diagnoses. These observations have increased interest in understanding decision-making psychology.

Many nonrational (i.e., not purely based in statistics) cognitive factors influence medical decisions and may lead to error. The most well-studied include heuristics, preferences for certainty, overconfidence, affective (emotional) influences, memory distortions, bias, and social forces such as fairness or blame.

Although the extent to which such cognitive processes play a role in anesthesia practice is unknown, anesthesia care frequently requires rapid, complex decisions that are most susceptible to decision errors. This review will examine current theories of human decision behavior, identify effects of nonrational cognitive processes on decision making, describe characteristic anesthesia decisions in this context, and suggest strategies to improve decision making. (Anesthesiology 2014; 120:204-17)
Fig. 1. Influences on decision making and diagnostic error. A variety of nonrational factors (i.e., factors not based purely in statistics or logic) influence decisions; these factors are themselves neither good nor bad. This figure highlights factors discussed in this review but is not comprehensive. Importantly, decisions may also utilize rational processes. This graphic is not intended to compare the proportion of cognitive effort or time that is rational compared with nonrational.
COGNITIVE BIASES

Anchor (narrowing in on what **I think the problem is**—not hearing from others)

Confirmation (only hearing what confirms what I think, not being open to considering that I’m wrong and being open to other possibilities)

Availability (what I see right now is what I know)

Ascertainment (prejudices, “that person”, “that nurse”, omg “here she goes again...”)

Hierarchical Biases
- Halo effect
- Passenger Effect (someone else is in charge—failure to question or ask who’s in charge) “It’s not my place” (even though I have valuable information or “know the answer”)
From individual awareness to Team awareness
“Teamwork isn’t a issue... I have a GREAT team!”
“Aviation safety was dependent on the recognition that pilots needed to embrace their role not just technical leaders, but team leaders”
Creating a safety culture doesn’t happen overnight…
“As the captain, I need you to cross-monitor me and speak up if anything is of concern.”

“I am the captain, I need you to listen to what I tell you and do your job”
“Flying a plane makes you a pilot...
“...Leading a team is what makes you the captain”
What does a Dr. Sully look and sound like?

Video of Physician leading Grand rounds
• Focus on the few…even “the one”
• Share stories (and data)
• Reason with Swiss Cheese
• Good catches to create resilience
• Think about how you think…and how it affects your own situational awareness
• Leaders are aware of their limitations and empower the entire team to speak up
Celebrate the small wins and focus on one STEPP at a time
Questions? Stay in Touch!

www.aha.org/teamtraining

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