AHA Team Training

C’mon! Not Another Initiative: Taking TeamSTEPPS into Just Culture and HROs

August 12, 2020

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Rules of Engagement

- **Audio for the webinar can be accessed in two ways:**
  - Through the phone (*Please mute your computer speakers)
  - Or through your computer
- **All hyperlinks on the screen are active if you click on them**
- **Q&A session**
  - Will be held at the end of the presentation
  - Written questions are encouraged throughout the presentation
    - To submit a question, type it into the Chat Area and send it at any time during the presentation

Upcoming Team Training Events

Webinar

September 9, 2020 | 1:00 – 2:00 PM ET

Register for the webinar *Psychological Safety and Building Team Strength in Crisis.*

Online Community Platform

Join Mighty Network to access exclusive content and connect with your peers to share stories, tools, and content.

Online Courses and Workshops – coming soon!

Today's Presenters

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UW Medicine - WISH

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Today's Objectives

Participants will…

Discuss the components and impact of a just culture

Differentiate human error, at-risk behavior and reckless behavior

Understand how TeamSTEPPS and high reliability organization concepts can help foster a just culture

UW MEDICINE

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UW Medicine Community

- 2,400 faculty members in 30 departments
- 4,700 clinical faculty across WWAMI region
- 4,500 students and trainees
    - Medical students, residents, fellows
    - Schools of Nursing
    - Pharmacy, PA, Rehab Therapies, RT
    - Other Ancillary Health Sciences Schools
- 30,000+ employees

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Let’s start with a case…

A patient is treated in the ED for sepsis. The physician ordered an antibiotic.

The ED nurse prepared the patient for transport to the inpatient unit and called report to the receiving nurse.

Simultaneously, the ED nurse intended to hang the antibiotic prior to transport but instead hung a bag of Heparin, which was intended for another patient. BCMA was available but the nurse did not utilize it.

When the patient arrives on the floor, the receiving nurse notices the bag of Heparin infusing and notifies the physician.

The infusion was stopped before the patient suffered any unintended consequences.

What if…

A patient is treated in the ED for sepsis. The physician ordered an antibiotic.

The ED nurse prepared the patient for transport to the inpatient unit and called report to the receiving nurse.

Simultaneously, the ED nurse intended to hang the antibiotic prior to transport but instead hung a bag of Heparin, which was intended for another patient. BCMA was available but the nurse did not utilize it.

When the patient arrives on the floor, the receiving nurse does not perform a bedside safety check, so does not notice that Heparin infusing. The patient receives the whole bag of heparin and no antibiotics.

The patient suffers major bleed and requires transfer to the ICU.

The patient's sepsis progresses and the patient codes. The patient dies within 24 hours of admission.

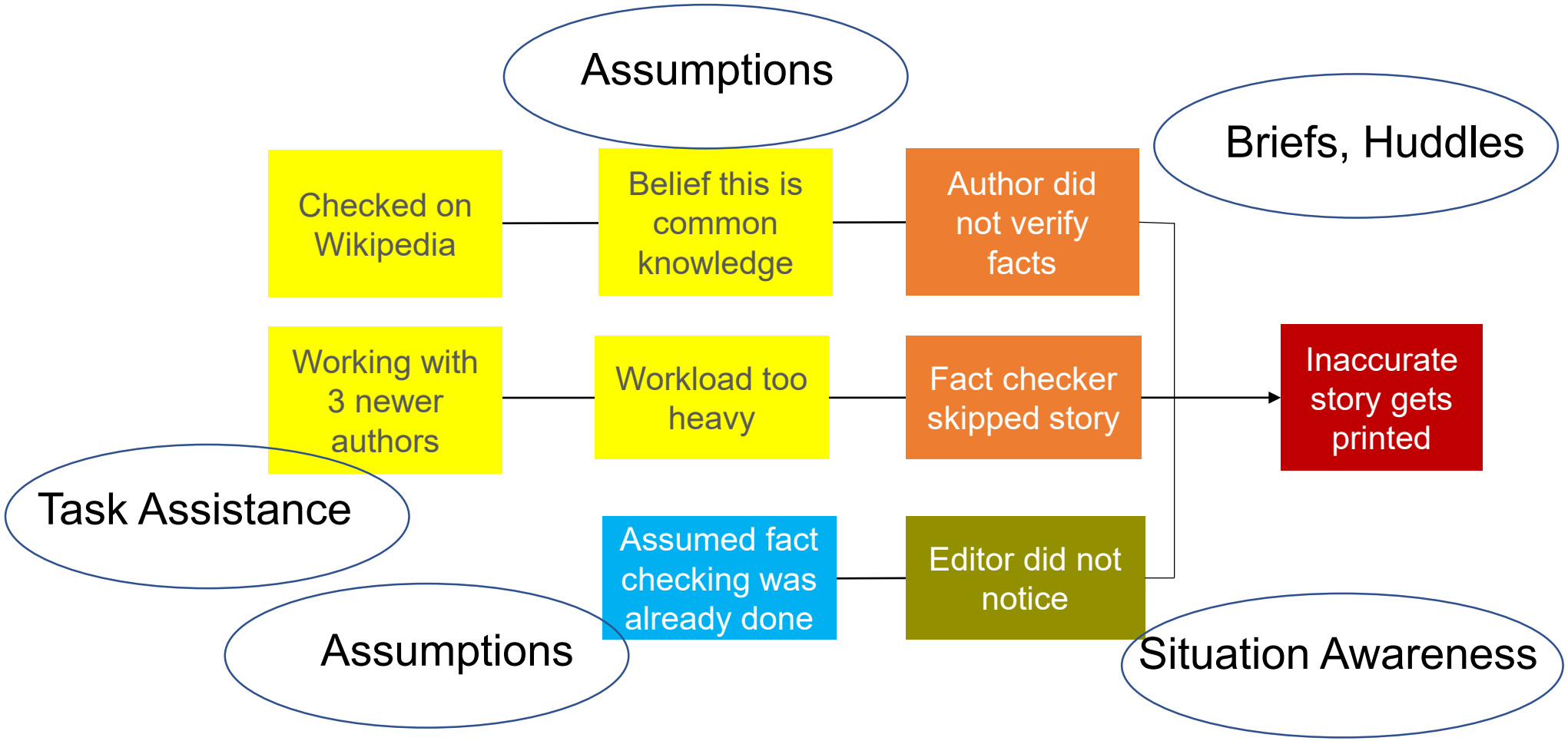
HRO – Team Training – Just Culture

High Reliability Element	High Reliability Behaviors and Practices	Supporting Team Training Tools	Integrating Just Culture
Sensitivity to operations	Front line employees are: • Better positioned to recognize failure or potential errors • Identify opportunities for improvement • Operations staff have a unique view of a current situation and unexpected situations • Big picture understanding	Situation Monitoring/Awareness, Check-back, Brief, Huddle, Debrief, Shared Mental Model	• Threshold questions (case investigation) • 3 voices (objective being front line when applicable)
Preoccupation with failure	• Any failure or deviation from the expected is reviewed for opportunities for improvement and to prevent continued failures • It is necessary to address all technical, human, and process failures immediately and completely • Fixate on how things might fail even when failure has not occurred • Near misses are consider opportunities	Brief, Huddle, Debrief, Situation Monitoring, Handoff tools, Mutual Support, Task assistance, CUS/Two Challenge	• Looking at the system as well as individual factors • 3R's • Focus on reliable system design • Coaching
Deference to expertise	Authority does not necessarily mean expertise: • Expertise take precedence • On-the-ground subject matter experts help provide situational assessment and response	Team Structure, Brief, Huddle, Leadership transfer skills training, SBAR, Situational Awarenes, CUS/Task Assistance	• 3 voices (objective view) • System design

HRO – Team Training – Just Culture

Resilience	• Anticipates failure or potential errors to effectively manage unexpected events • Involves identifying errors and innovating simultaneously • Dynamic process of correcting and creating solutions	Situation and cross-monitoring and task assistance, CUS/Two Challenge), Briefs, Huddles, Debriefs Simulation scenarios of applied team training concepts allows for studying complex events and the latent and active conditions that contribute	• Coaching • Consoling • 3R's • System
Reluctance to simplify	Embrace the complexity of the organization • Conduct detailed analyses like root cause analysis to understand problems • Reject simple explanations for failure	Team Structure, Brief, Debrief, Handoff, Situation Monitoring Simulation scenarios of applied team training concepts allows for studying complex events and the latent and active conditions that contribute	• Threshold questions • 3 voices • Address the three behaviors

Situation Monitoring/Mutual Support



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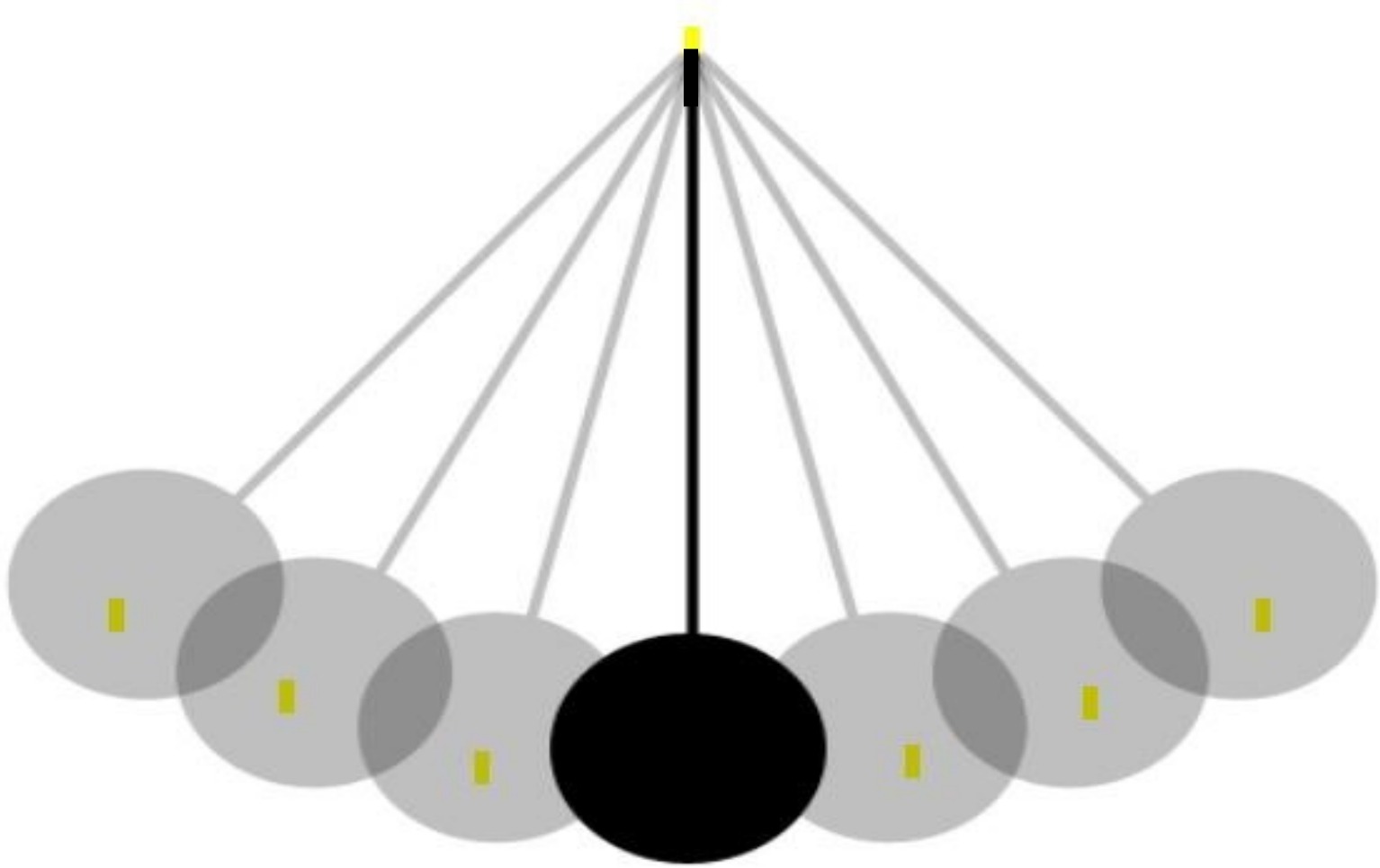
A Cause of the Human Error | Behavioral Choice | Human Error

A Cause of the Behavioral Choice | The Undesired Outcome

The Continuum of Accountability



Blame Free

Punitive

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System Basis of Errors

- “People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?...

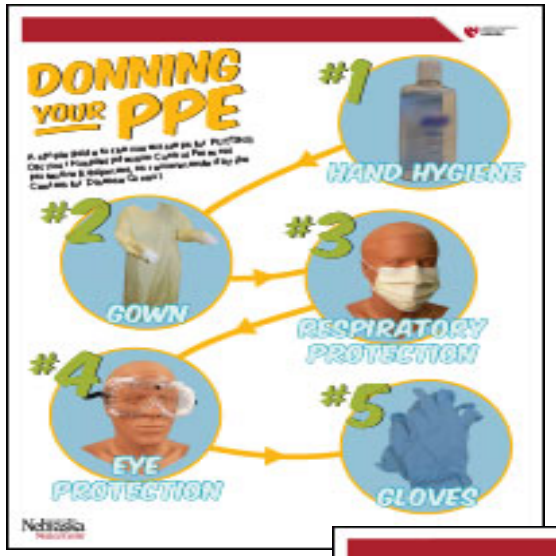
- …**Wrong.** The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

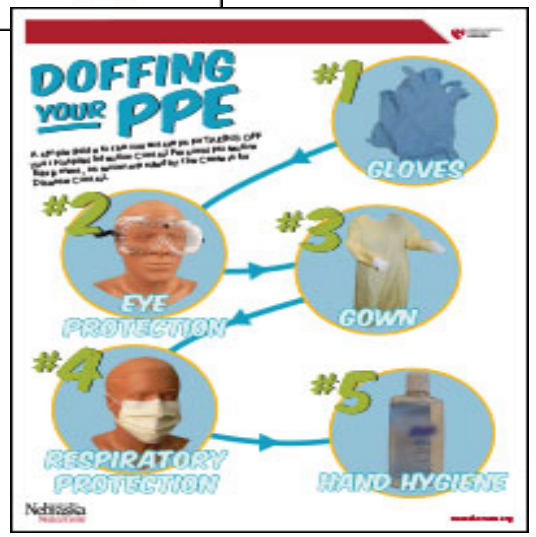
Don Norman
The Design of Everyday Things
2000; 2013

Where we want to be…

To Err is Human

To Drift is Human





CUS/Two Challenge

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What is Just Culture?

The acknowledgement that all humans **are destined to make mistakes and drift into at - risk behavioral** choices regardless of how well the system is designed.

Shift focus from error and outcomes to system design and behavioral choices.

The Three "Voices"

IMPOSER

Enforcing the rules
Determines risk and tolerability

SUBJECTIVE STANDARD

What did the person perceive?
Why did the person act as such?

OBJECTIVE STANDARD

Reasonable Person Test ("similar person, similarly situated")
For JC, preference is within your organization/unit culture

OBJECTIVE STANDARD:
Be wary of your (imposer's) personal bias and past experiences.

"Only wear one hat!"

Threshold Questions

- What happened?
- What NORMALLY happens?
- What does the procedure require?
- Why did it happen?
- How was the organization managing the risk?

Just Culture's Three Behaviors*

Human Error

Inadvertent action: slip, lapse, mistake

Manage through changes in:

- Processes
- Procedures
- Training
- Design
- Environment
- Behavioral Choices

CONSOLE

At-Risk Behavior

A choice: risk not recognized or believed justified

Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

COACH

Reckless Behavior

Conscious disregard of a substantial & unjustifiable risk

Manage through:

- Remedial action
- Disciplinary action
- Punitive action

DISCIPLINE

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*From Outcome Engenuity

Human Error

- It is inadvertent, and a result often associated with other factors:
  - Was there a “system” contribution to the error?
  - Were there personal performance factors?
  - Did the individual make a decision/choice upstream that increased the possibility of an error occurring?
- It is never JUST human error

Human Error – Why Does it Happen?

What are the **personal** performance shaping factors?

- Human factors
- Fatigue
- Fitness for duty
- Stress
- Distractibility
- Experience
- Task tension and engagement
- Motivation
- Mental and physical hardiness

What are the **system**-based causes?

- Lack of patient/product information
- Failure to communicate
- Storage and access
- Device failure
- Lack of patient education
- Lack of staff education /orientation/supervision
- Environmental, workflow or staffing
- Culture

At-Risk Behavior

- A behavioral choice that increases risk without perceiving the risk or is mistakenly believing to be justified
- Driven by perception of consequences

This is where TeamSTEPPS can proactively impact culture

At-Risk Behavior – Why Does it Happen?

Why did the decision make sense at the time to the **individual**?

- Why was the decision made?
- Incentives to cut the corner?
- Barriers to correct behaviors?
- Perceptions of risk?
- Problem solving?
- How prevalent is the behavior? (What normally happens?)

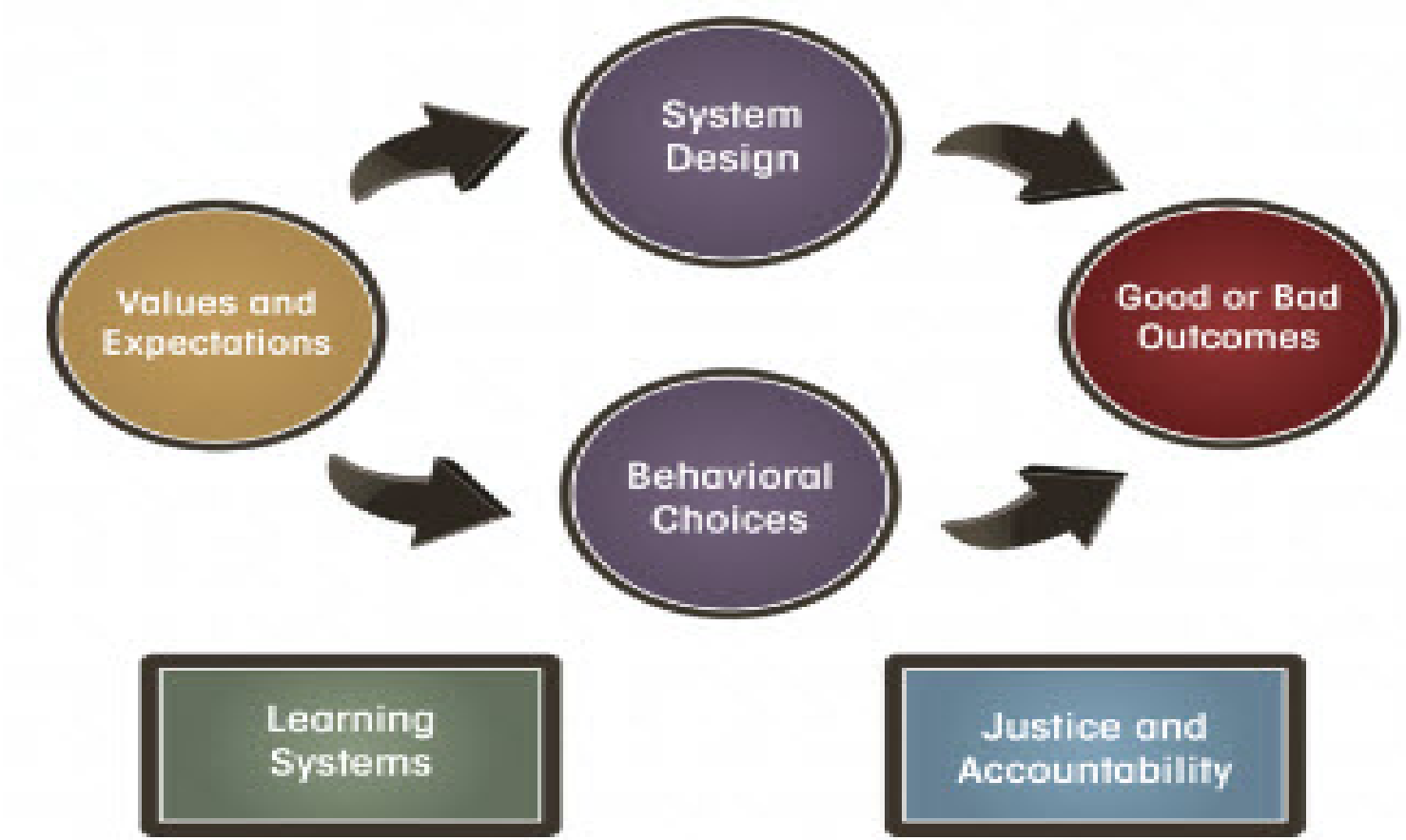
What are the **system**-based causes?

- Lack of patient/product information
- Failure to communicate
- Storage and access
- Device failure
- Lack of patient education
- Lack of staff education /orientation/supervision
- Environmental, workflow or staffing
- Culture

Reckless Behavior

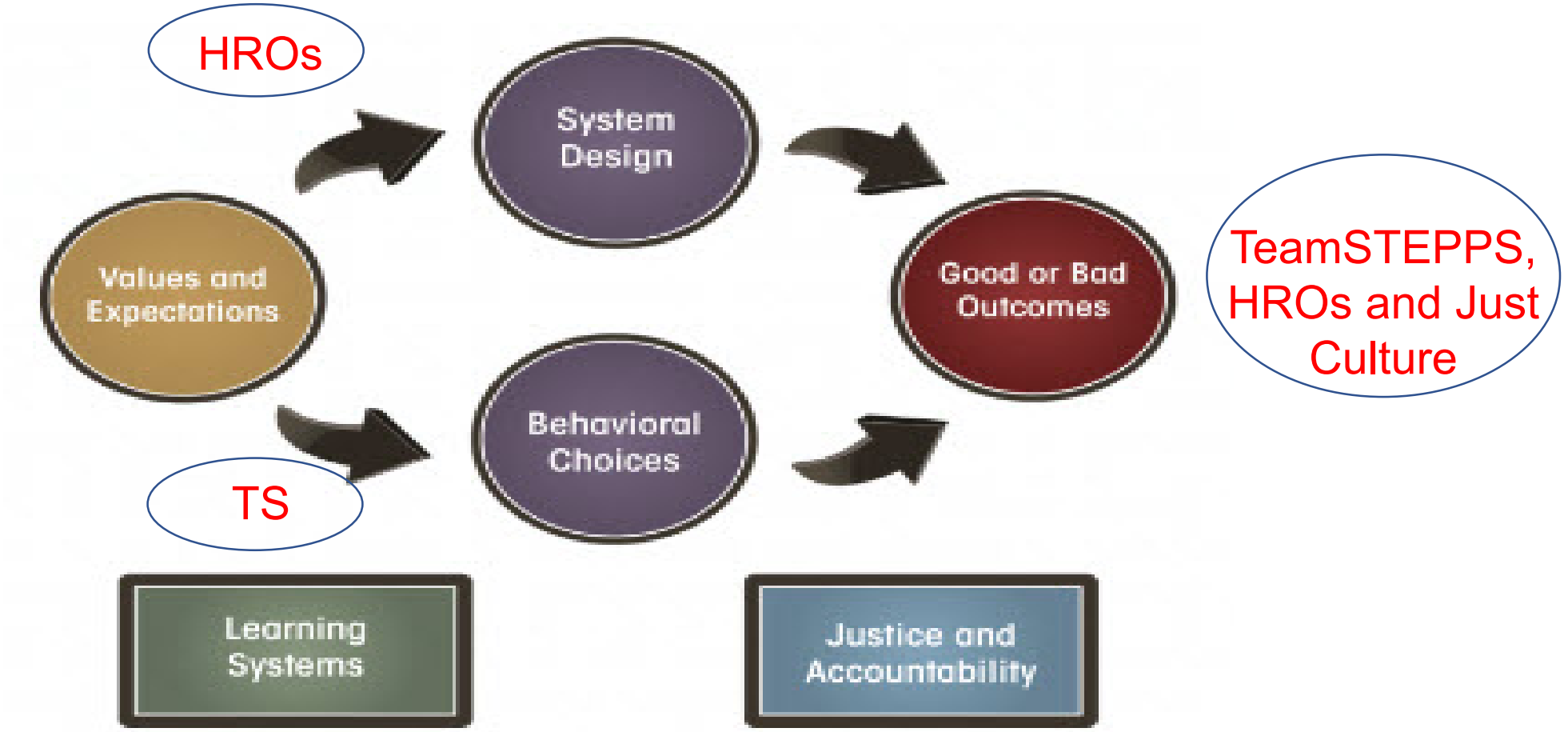
- Conscious disregard of substantial and unjustifiable risk
- Manage through:
  - Disciplinary action
  - What is in the best interest of your organization and its learning culture?

Attributes / Results of a Just Culture



Outcome Engenuity Just Culture Model

Putting It All Together!



Outcome Engenuity Just Culture Model

Key Takeaways

- Just Culture is about identifying risk, not finding fault
- Evaluate systems and behaviors, not outcomes
- Assess and mitigate bias throughout the process
- **Integrating TeamSTEPPS, HRO and Just Culture is integral in creating culture of safety**
  - Not individual initiatives

THANK YOU

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Questions? Stay in Touch!

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