AHA Team Training

Simple STEPPS for Engaging Physicians Partners to Sustain Your Safety Culture

March 10, 2021

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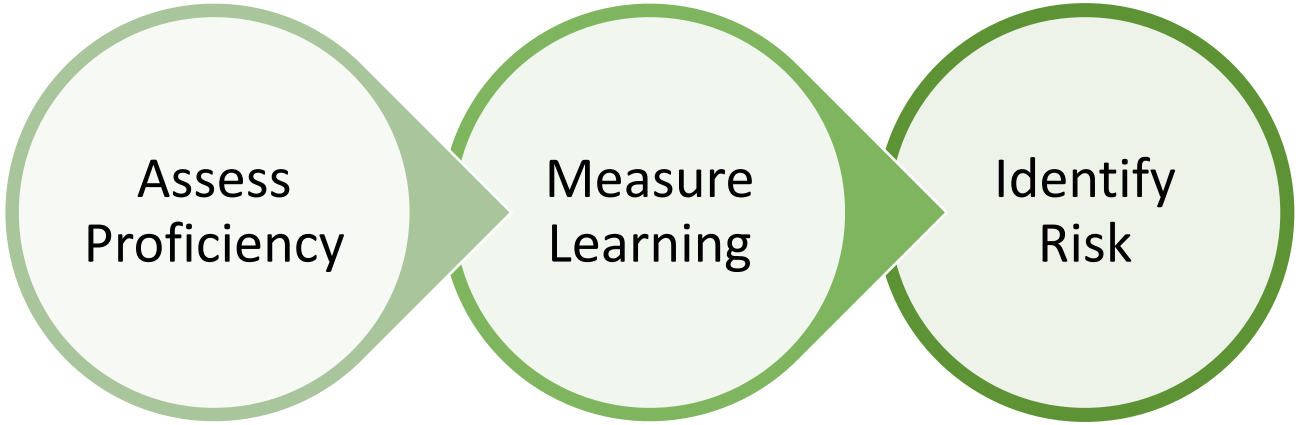

“Relias’ performance management platform has played a crucial role in our progress and pursuit of better health, better care and lower cost. Our success is almost single-handedly the result of our wide-scale focus on the elimination of irrational variation, and the Relias technology is our empirical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

-St. Luke’s Health System

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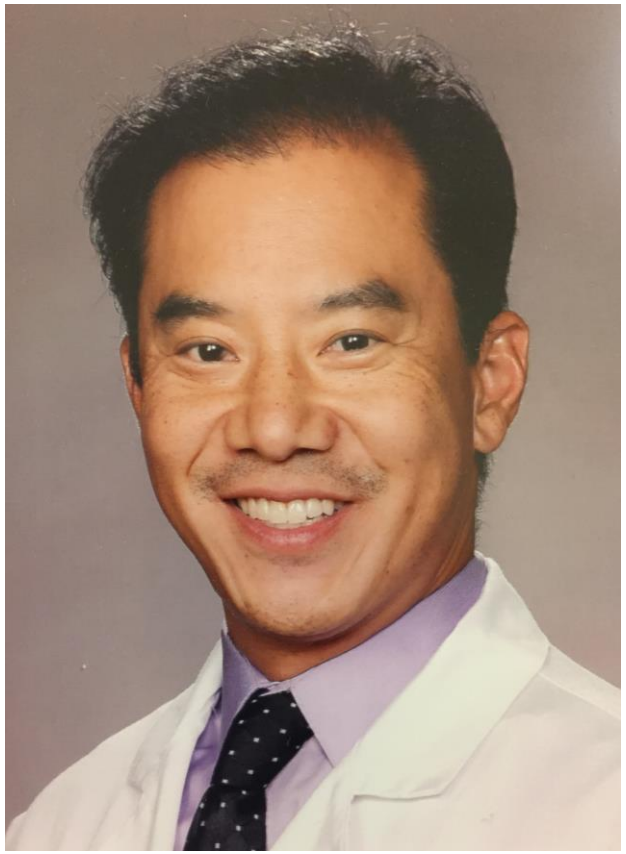
Today's Presenter



Jason Cheng D. O.

Safety and Human Factors Education Co-Chair

Kaiser Permanente Southern California Region, Department of Anesthesiology

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Today's Objectives

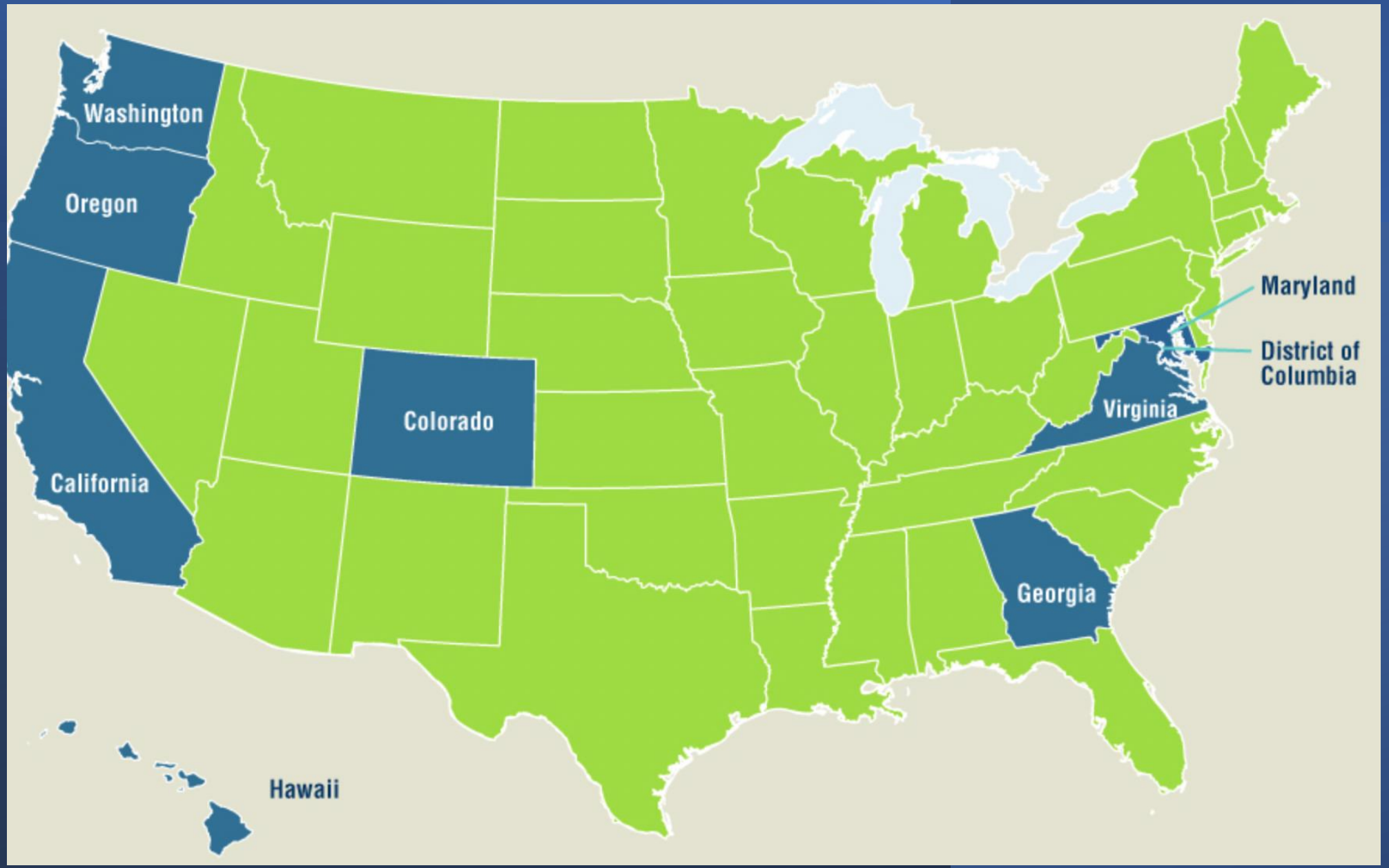
Participants will..

- 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

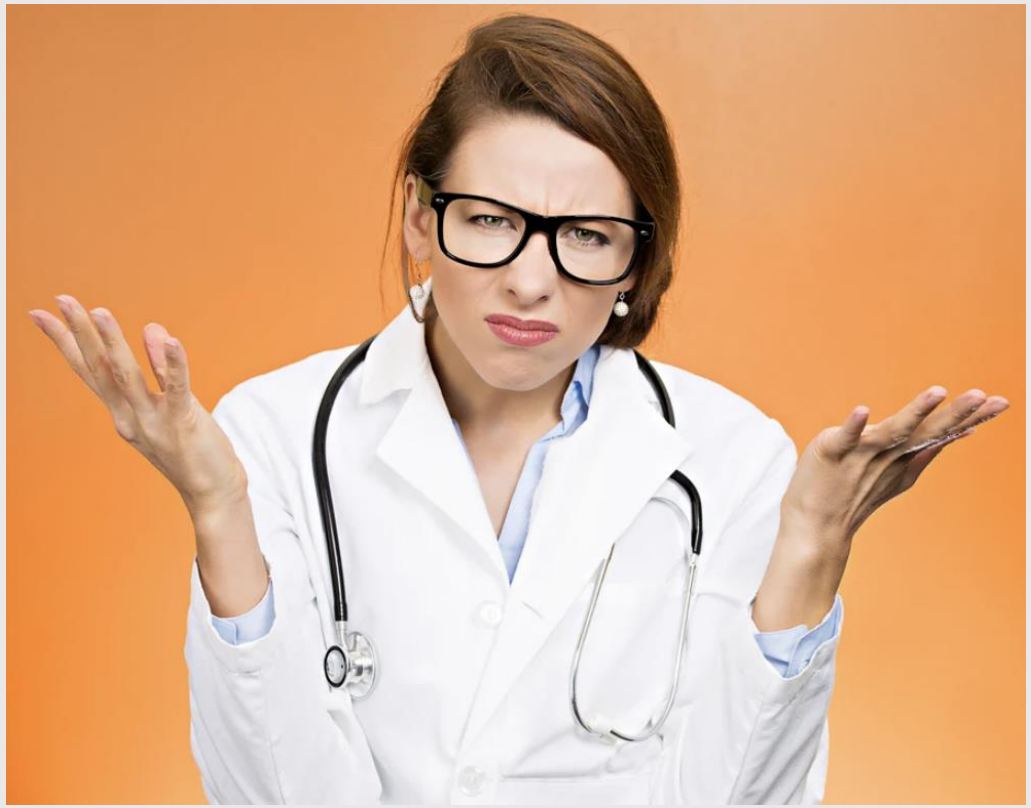
64,000 Nurses

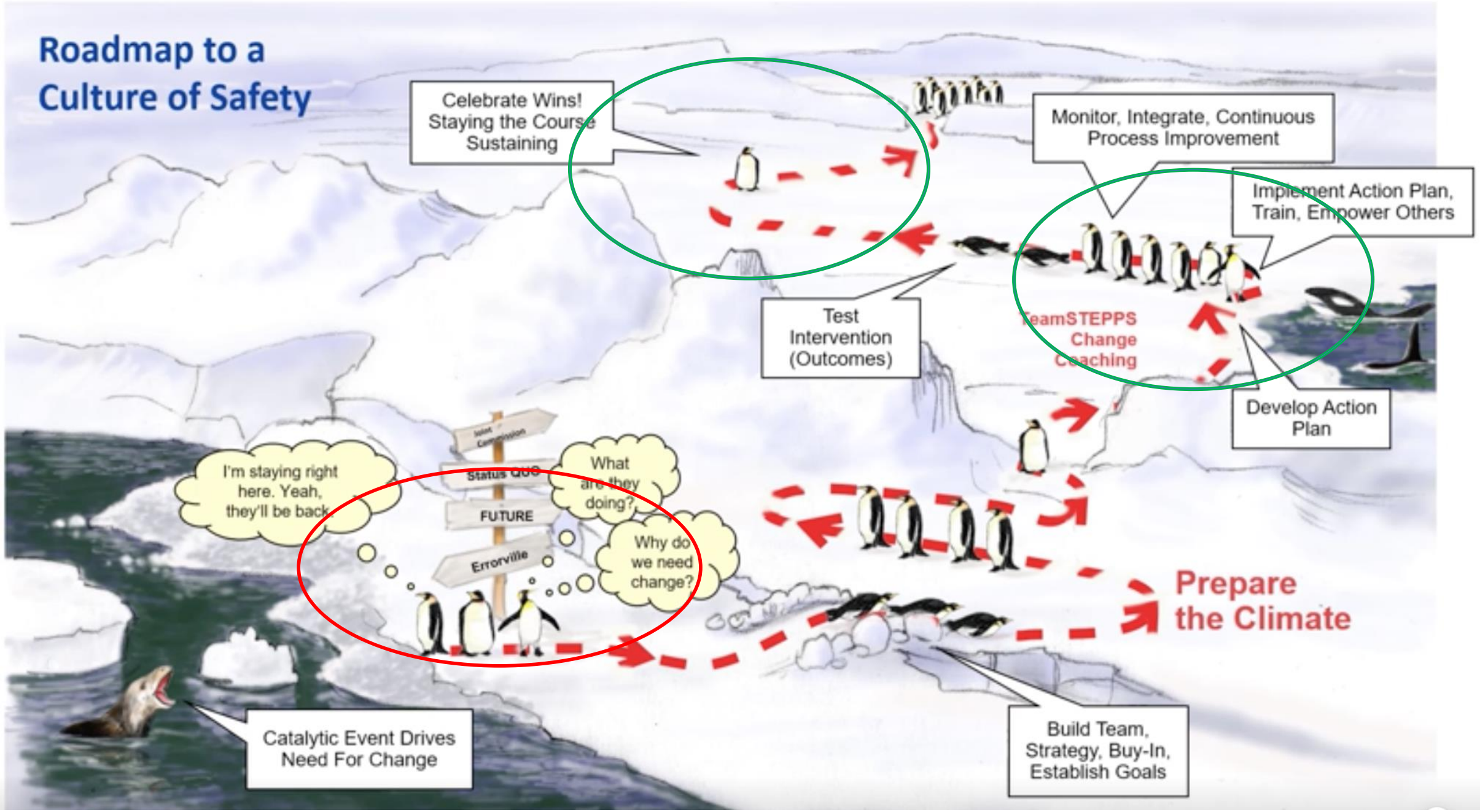
12 Million Members



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
I'm staying right here. Yeah, they'll be back.
What are they doing?
Why do we need change?
Status QUO
FUTURE
Errorville
Prepare the Climate
Catalytic Event Drives Need For Change
Build Team, Strategy, Buy-In, Establish Goals

Share the story

Safety Leaders--Iqbal Anwar, MD

Perioperative Physician Director
Kaiser Permanente West Los Angeles

Memories and emotions from a single event...

Safety Huddle

- 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 62 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.

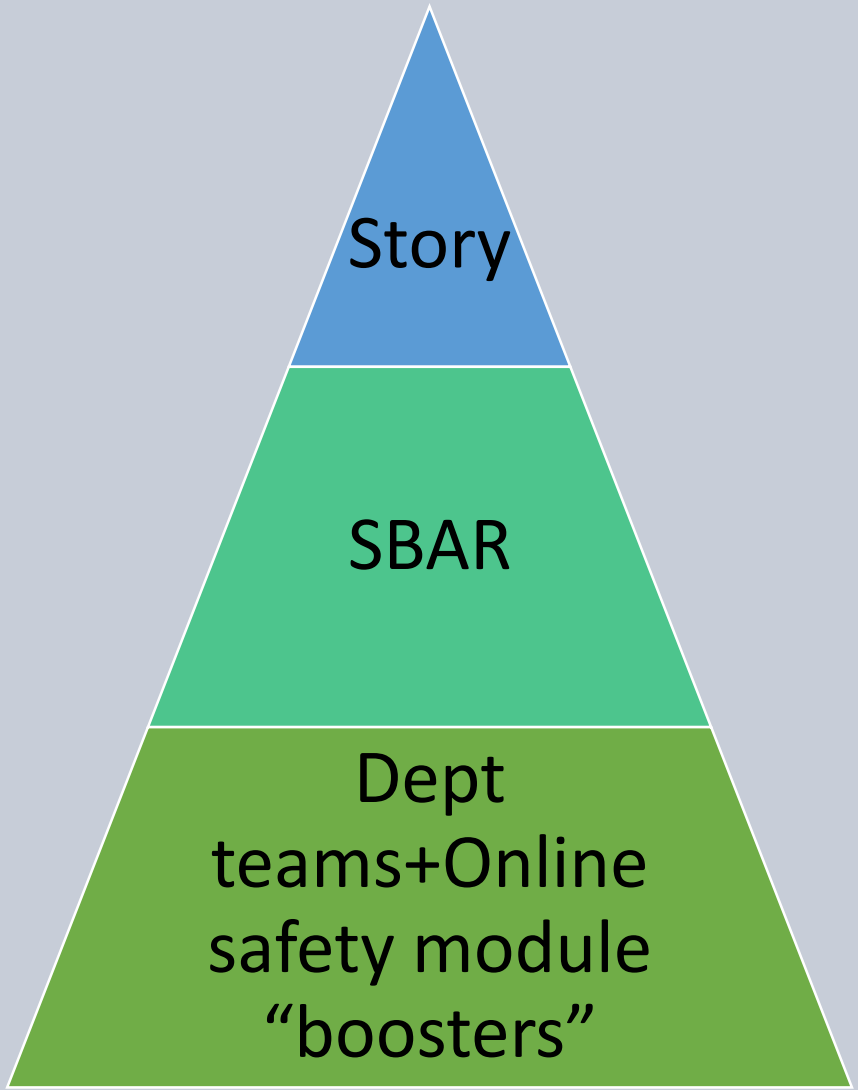
B – The patient had multiple lesions on his back and the lesion that was to be excised on the day of surgery was misidentified. The patient and a family member were part of the procedure verification and they had pointed to the incorrect lesion. Once this was identified as the incorrect lesion, a second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

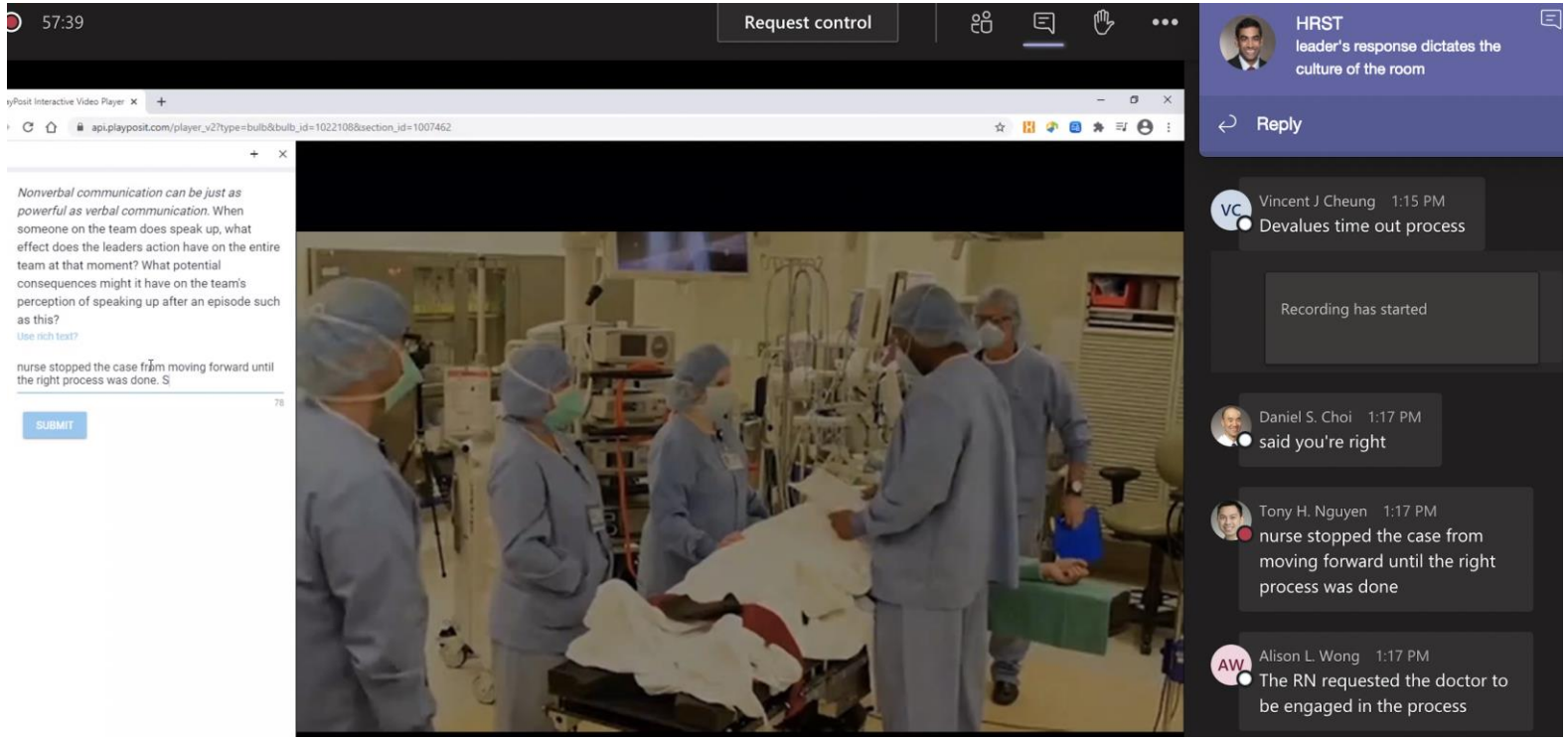
A – At the time of the first surgery the General Surgery clinic did not have a standardized process that included Univeral Protocol components. The picture taken in Dermatology of the lesion was not part of the verification process and there was reliance on the patient to identify the correct lesion.

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:

Area of Implementation	**Action to Be Taken:**
Procedure Area	Photo verification will take place as part of the surgical briefing. (Marking)?
Procedure Area	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.




57:39
Request control
HRST
leader's response dictates the culture of the room
Reply
Nonverbal communication can be just as powerful as verbal communication. When someone on the team does speak up, what effect does the leaders action have on the entire team at that moment? What potential consequences might it have on the team's perception of speaking up after an episode such as this?
Use rich text?
nurse stopped the case from moving forward until the right process was done. S
SUBMIT
Vincent J Cheung 1:15 PM
Devalues time out process
Recording has started
Daniel S. Choi 1:17 PM
said you're right
Tony H. Nguyen 1:17 PM
nurse stopped the case from moving forward until the right process was done
Alison L. Wong 1:17 PM
The RN requested the doctor to be engaged in the process

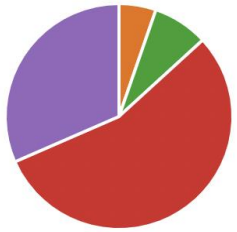

00:22
KAISER PERMANENTE
Jose Alaniz 1:14 PM
Feel free to answer the prompts in the chat
Last read
Shaun P Patel 1:15 PM
not inviting
Tony H. Nguyen 1:15 PM
opposite of speak up culture
Keith R. Aceron 1:15 PM
rushed
Vincent J Cheung 1:15 PM
Devalues time out process
Recording has started

Build a system of feedback from your audience

1. It is easy to SPEAK UP about errors, mistakes, or ethical concerns.

More Details

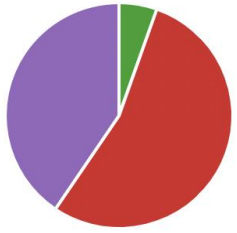
Strongly Disagree	0
Disagree	2
Neutral	3
Agree	21
Strongly agree	12



2. The CULTURE in my dept makes it EASY TO LEARN from my errors or errors of others.

More Details

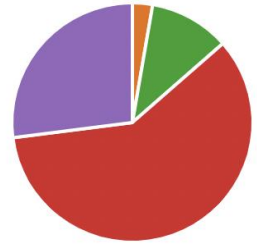
Strongly Disagree	0
Disagree	0
Neutral	2
Agree	20
Strongly agree	15



3. We communicate openly and honestly with each other, even when our opinions differ.

More Details

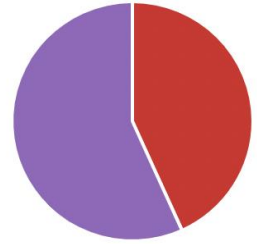
Strongly Disagree	0
Disagree	1
Neutral	4
Agree	22
Strongly agree	10



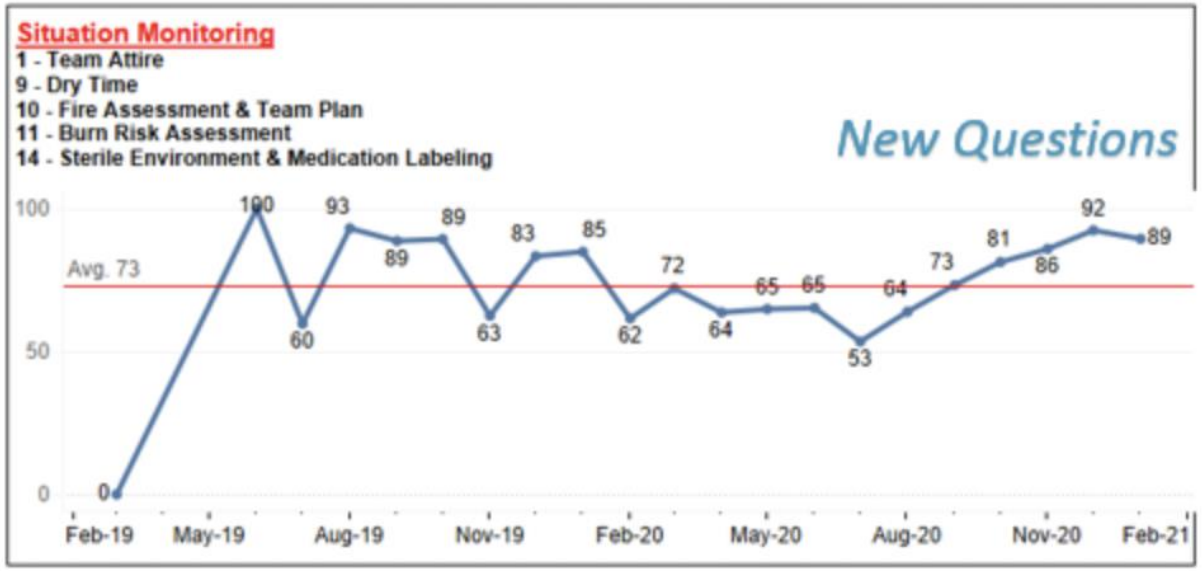
4. The people i work with treat each other with respect despite differences.

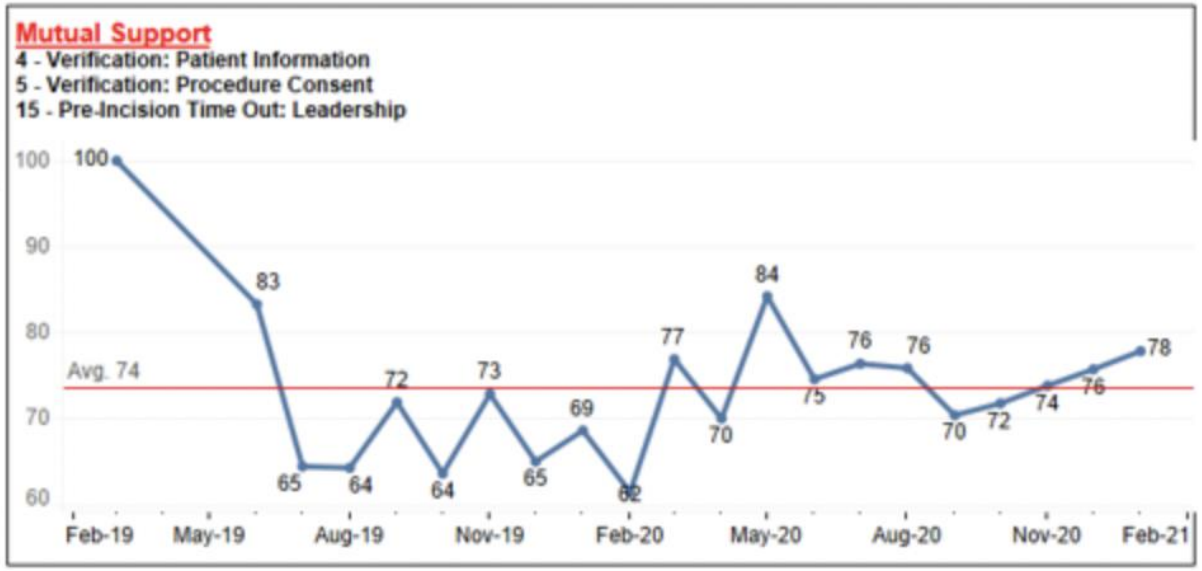
More Details

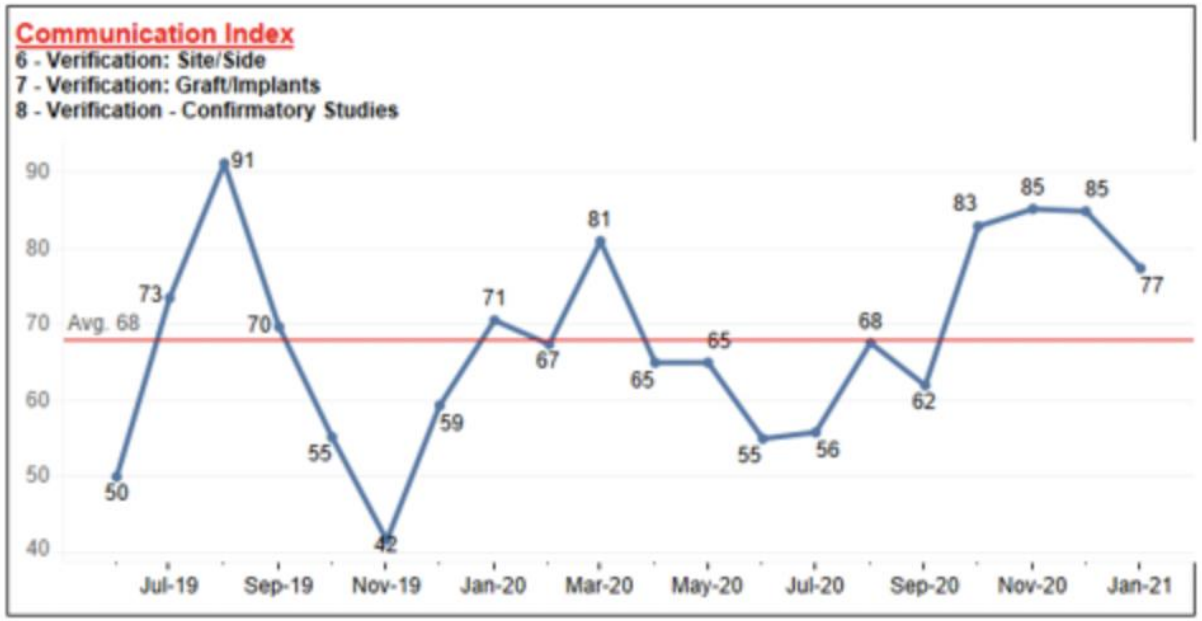
Strongly Disagree	0
Disagree	0
Neutral	0
Agree	16
Strongly agree	21

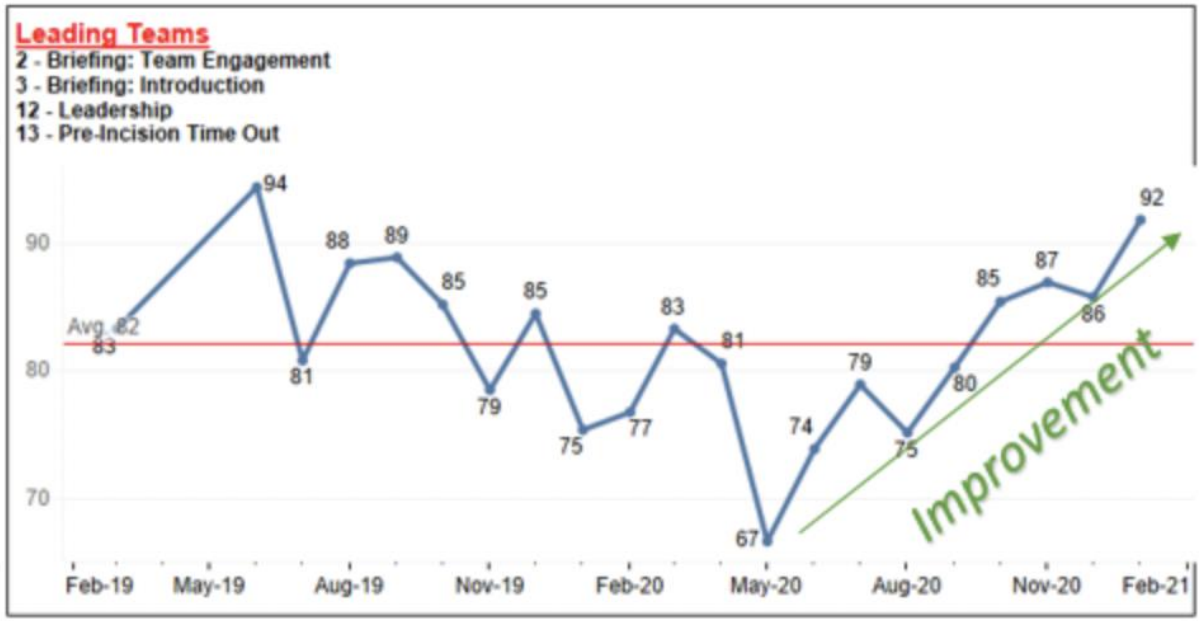


Data helps support your story



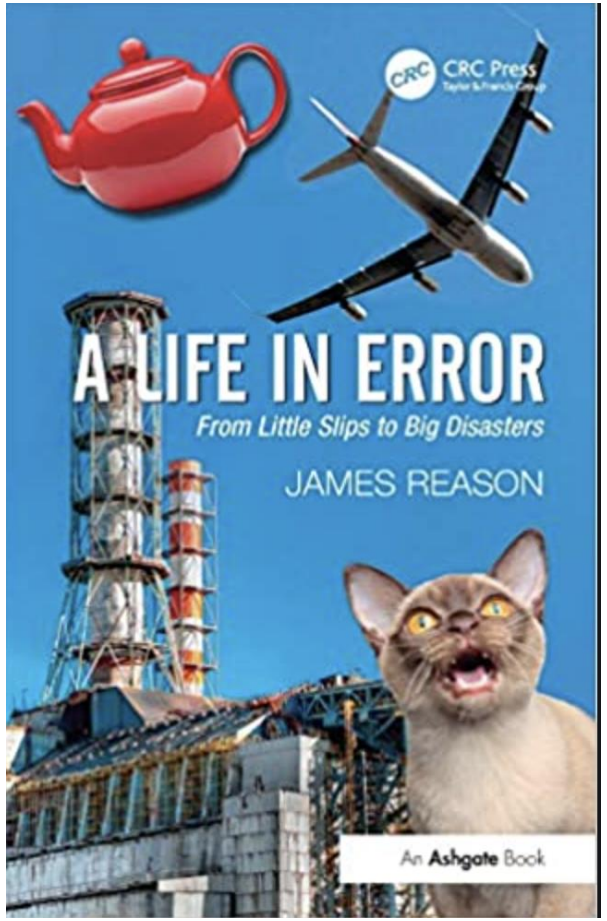






Reason with Swiss Cheese…

Safety Rounds w/ Dr. Reason

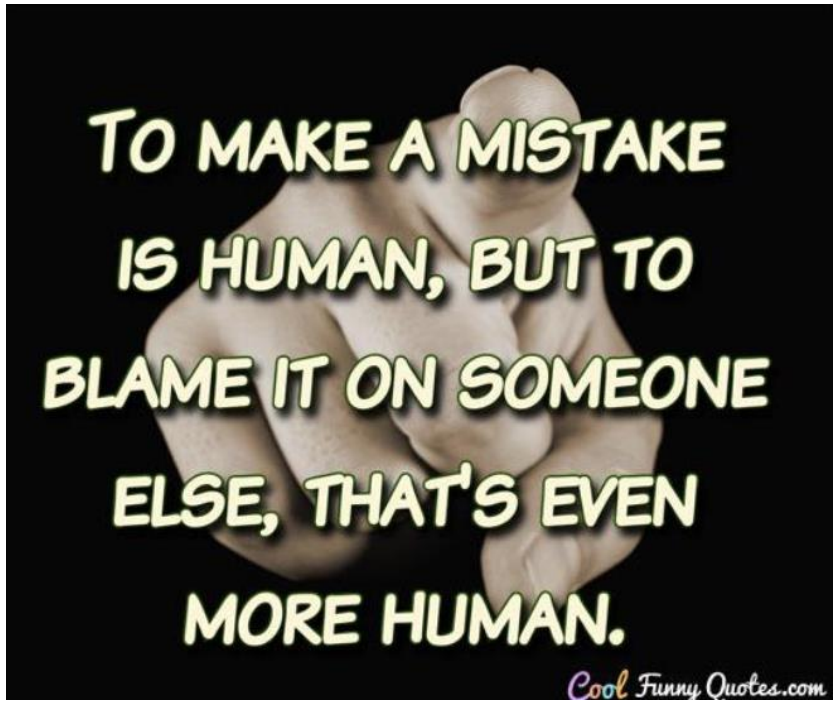


"Health care training, particularly that of doctors, is predicated on a belief in trained perfectability"

"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."

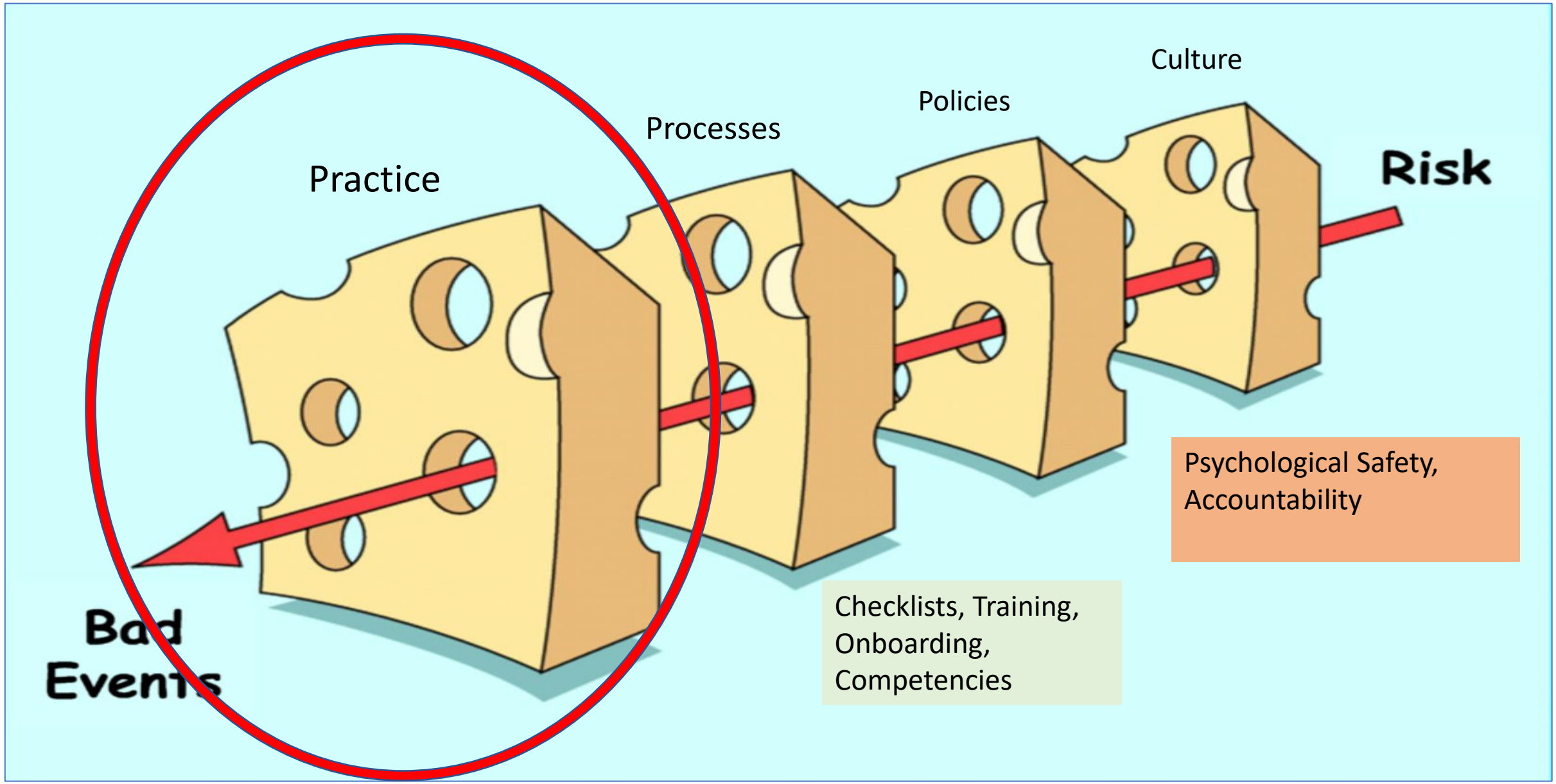
Be aware of what our instinctive behaviors!



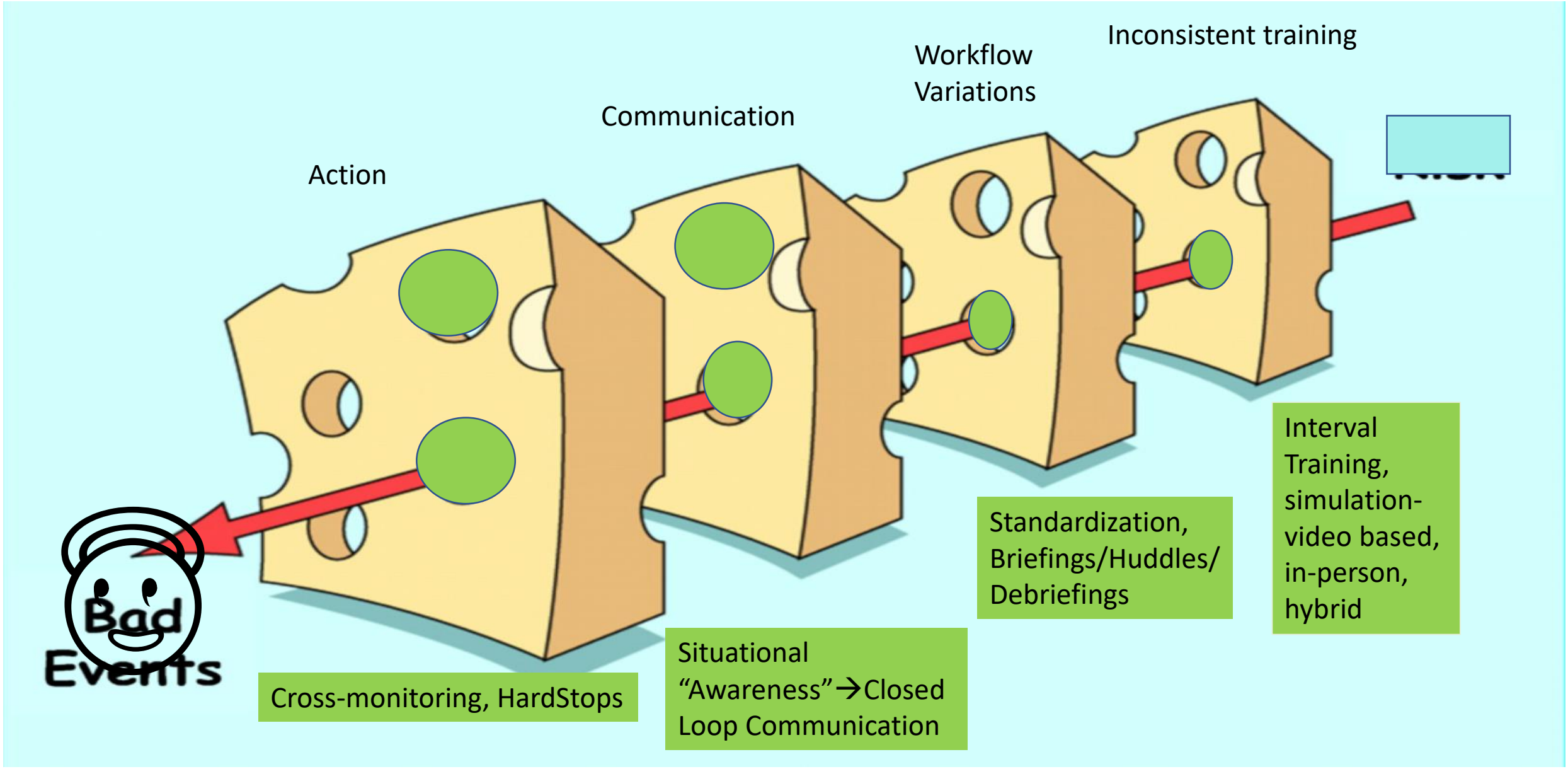
TO ERR IS HUMAN

- 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.

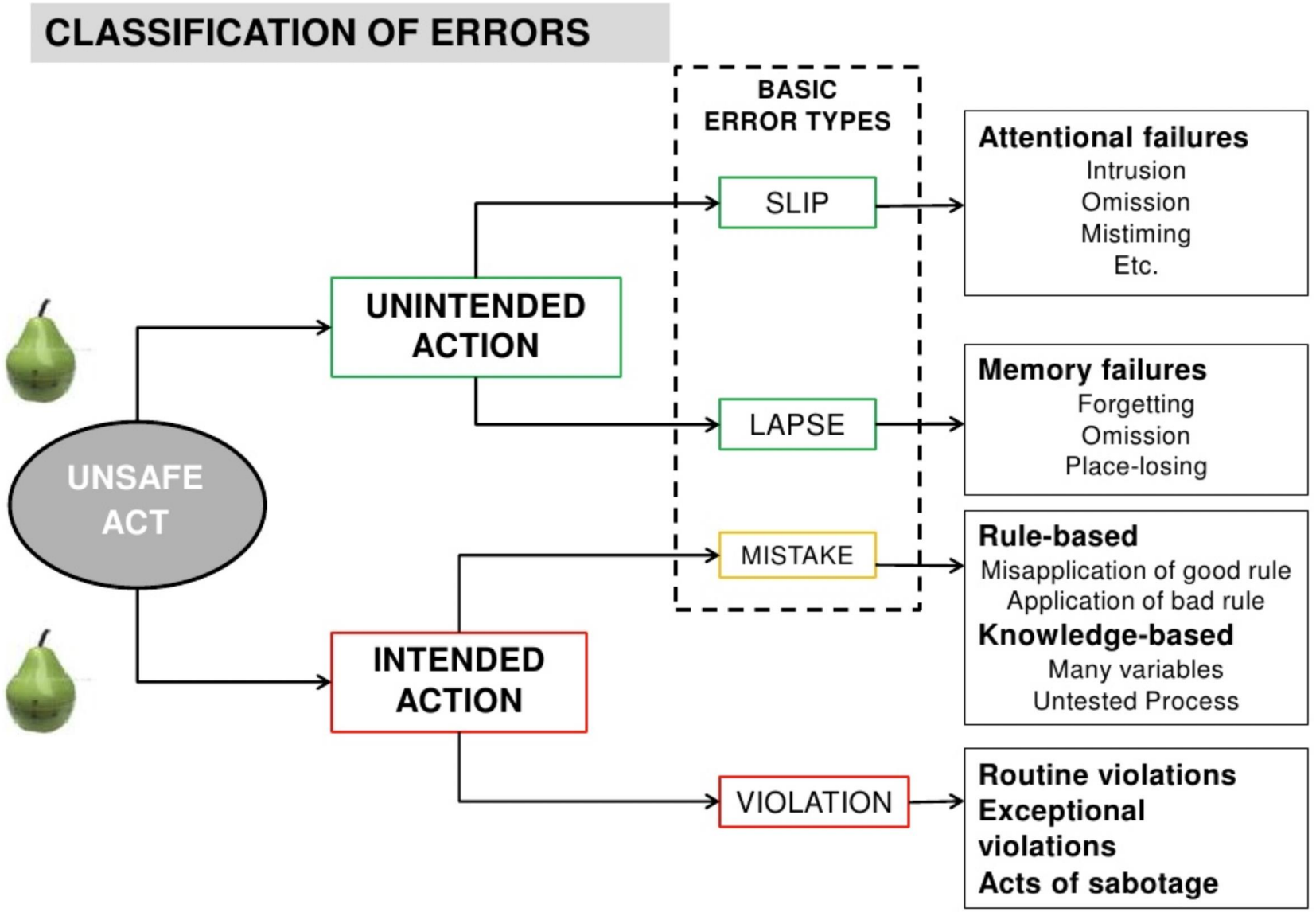
LATENT SAFETY FACTORS



Active Failures--Practice Slice



Opportunities—Root cause analysis, Case reports, Quality improvement, journal club, etc.



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.

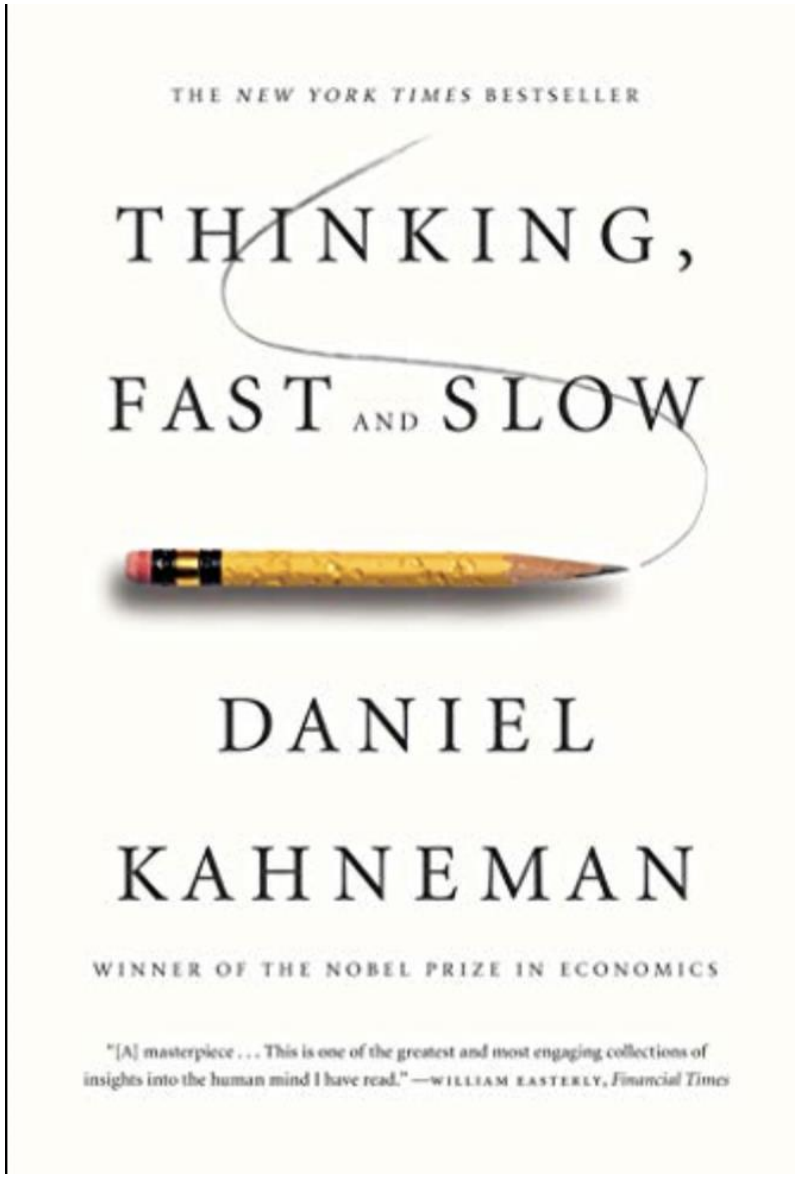
ABSTRACT

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

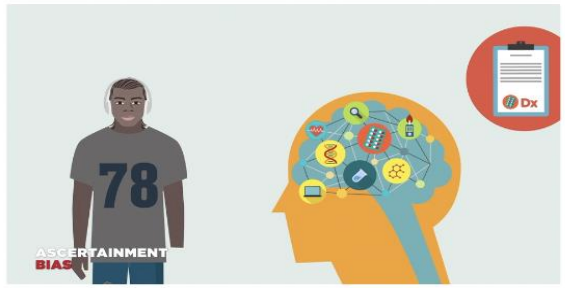
- Halo effect
- Passenger Effect (someone else is in charge—failure to question or ask who's in charge) "It's not my place" (even though I have valuable information or "know the answer")

https://kpactionplans.org/dex/

Why talk about diagnostic errors?
Michael Kanter, MD CPPS

Partnering with patients to drive diagnostic excellence
Susie Becken, Patient Advocate

Avoiding diagnostic errors
Lawrence Lurvey, MD JD



Understanding bias

Self-awareness of unconscious bias
Shari Chevez, MD

Always make and document a differential diagnosis
Kim Tran, MD FACP

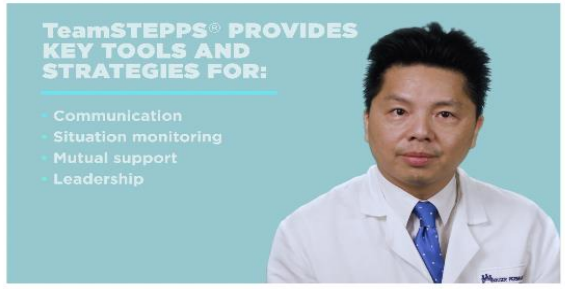
The diagnostic process is a team sport
Kerry Litman, MD CPPS

Back office teamwork
Aileen Oh, MSN RN

Raising your diagnostic awareness
Ronald Loo, MD

A physician's perspective
William Strull, MD CPPS CIP

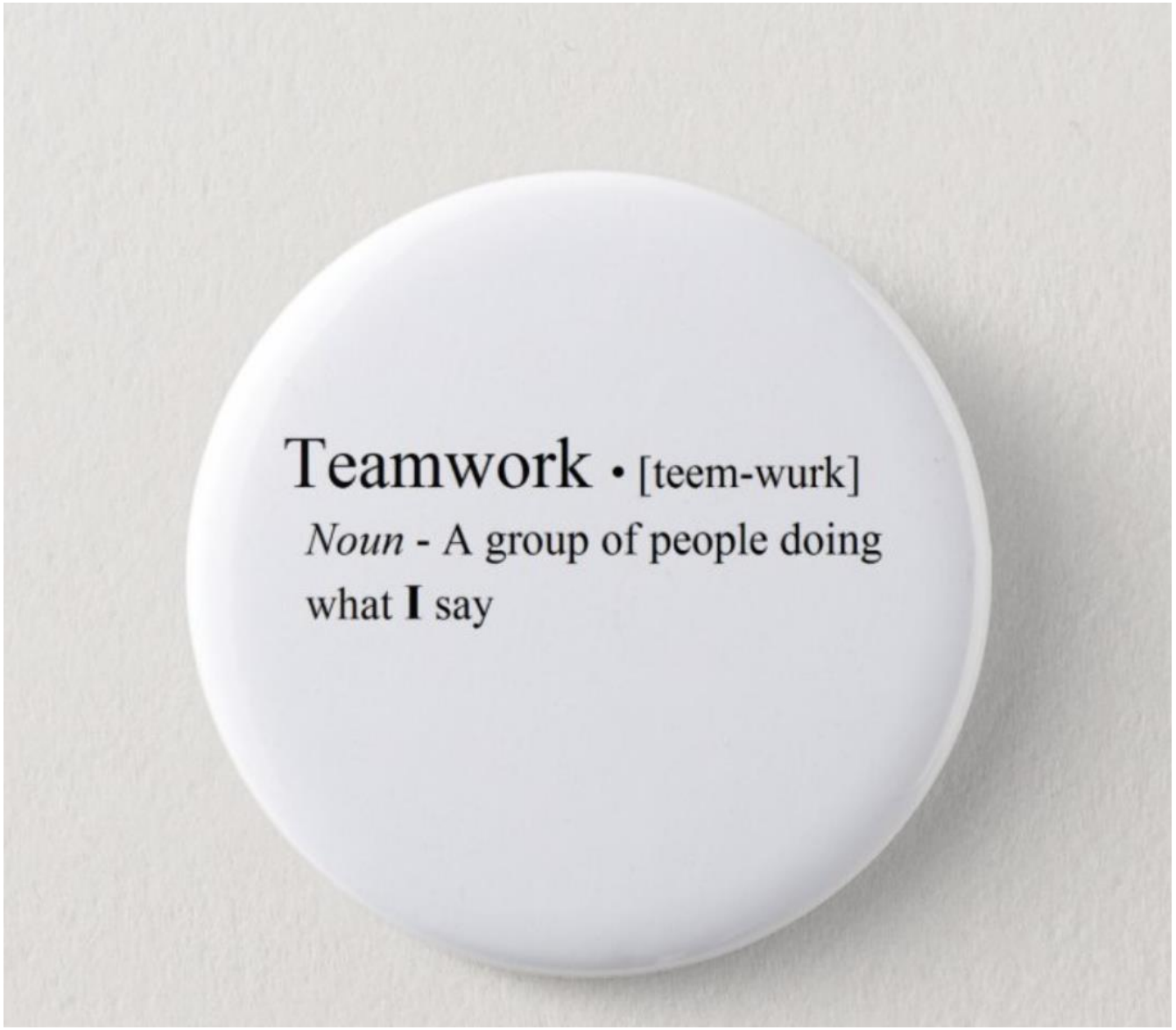
Systems to achieve diagnostic excellence



Tools for patient safety
Vu Nguyen, MD

From individual awareness to Team awareness

“Teamwork isn’t a issue…I have a GREAT team!”



https://youtu.be/2mnuQkmywrc

“Aviation safety was dependent on the recognition that pilots needed to embrace their role not just technical leaders, but team leaders”

Crew Resource Management

Utilization of resources available to a team to manage human error

5th — Threat & Error Management integrated into CRM, Errors = Ubiquitous & Inevitable, Teamwork Required to Avoid, Trap, and Mitigate Errors

4th — FAA – Advanced Qualified Program, CRM integrated into LOFT's, LOE's, Proven effectiveness by LOSA

3rd — CRM integrated with technical training, Instructors and Check airmen also trained for HF competencies, FA's, Dispatch, Mechanics also trained

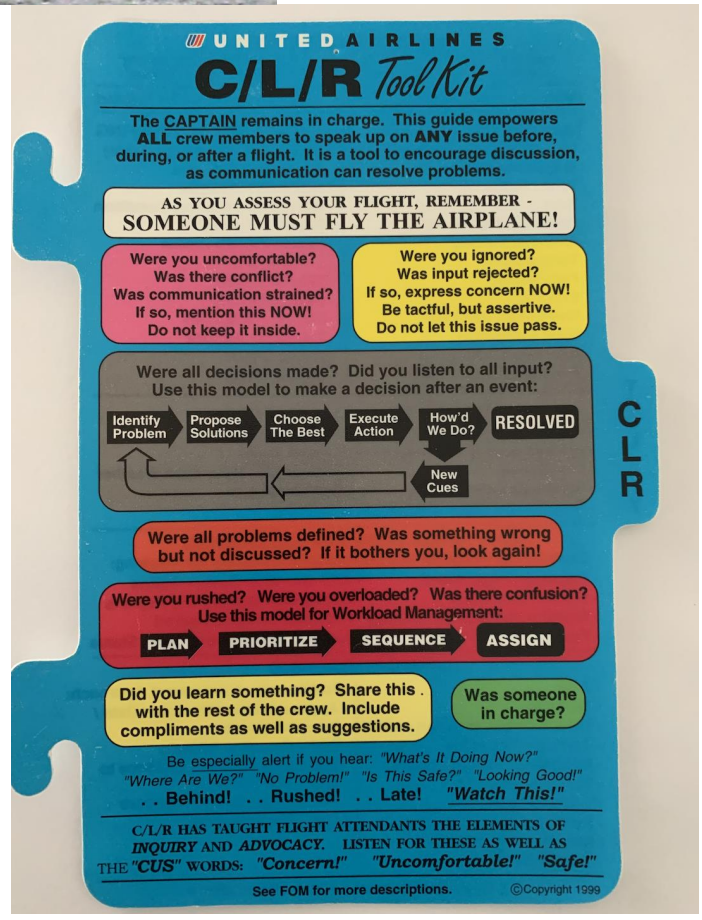
2nd — Cockpit to Crew, Aviation based, Briefing strategies, Team-Building, Situational Awareness, More modular

1st — UAL 1981 – C/L/R , Psychology Based, Gen mgmt concepts, Separate component, perceived as "charm school"

NASA Workshop - Resource Management on the Flight Deck

Interpersonal communications
Decision Making
Leadership

1979 1986 1990 2000 2009



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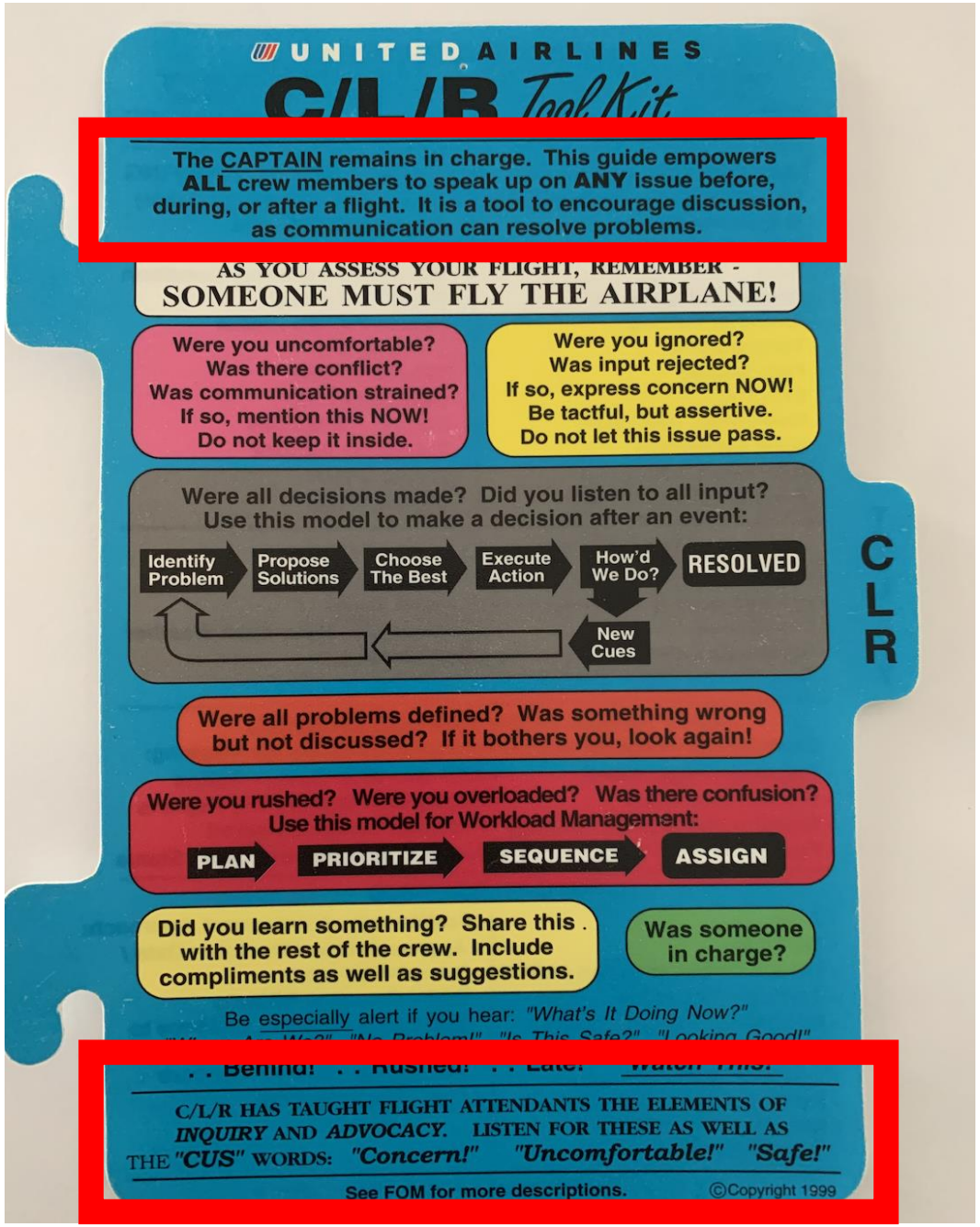
"As the captain, I need you to cross-monitor me and speak up if anything is of concern."

"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

Summary

- 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

jason.y.cheng@kp.org

AHA Team Training

Questions? Stay in Touch!

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