



## AHA Team Training

# Simple STEPPS for Engaging Physicians Partners to Sustain Your Safety Culture

March 10, 2021

Sponsored by:

RELIAS



AHA CENTER FOR HEALTH

**INNOVATION**

# Upcoming Team Training Events

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## ***Webinars***

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

## ***Virtual Courses and Workshops***

Workshop Series: Improving Team Structure: Engaging Patients and Families as Team Members, April 20<sup>th</sup> – May 11<sup>th</sup> [Register here!](#)

## ***Online Community Platform***

[Join Mighty Network](#) to access exclusive content and connect with your peers to share stories, tools, and content.

# Introducing: Advancing Care Conference 2021

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For more information, visit us at: <https://advancingcare.aha.org/>

Relias helps hospitals and health systems improve outcomes and reduce risk



### 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



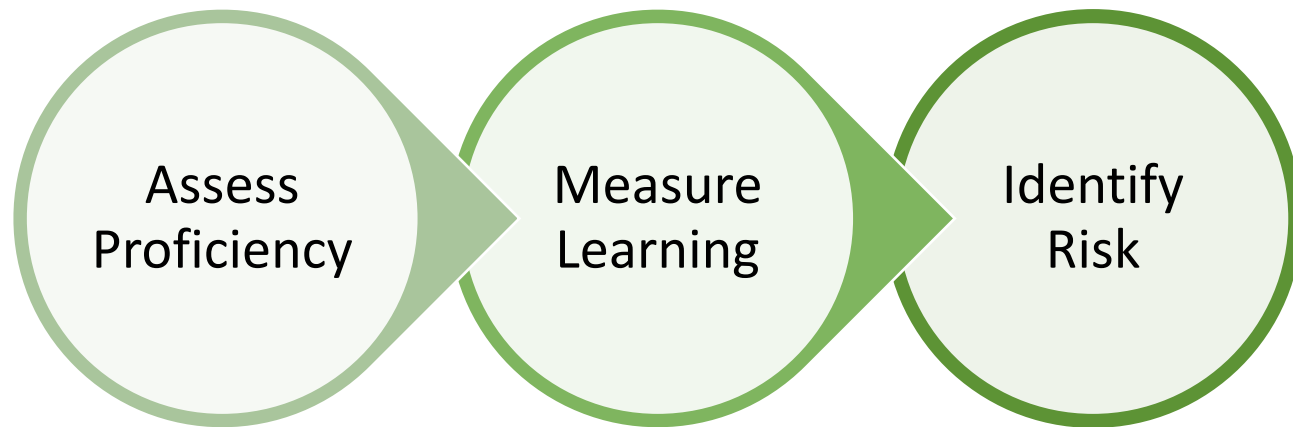
Empower organizations on their journey to high reliability to improve the healthcare experience for all

Learn more at [Relias.com](https://Relias.com)



# The Personalized Learning Process

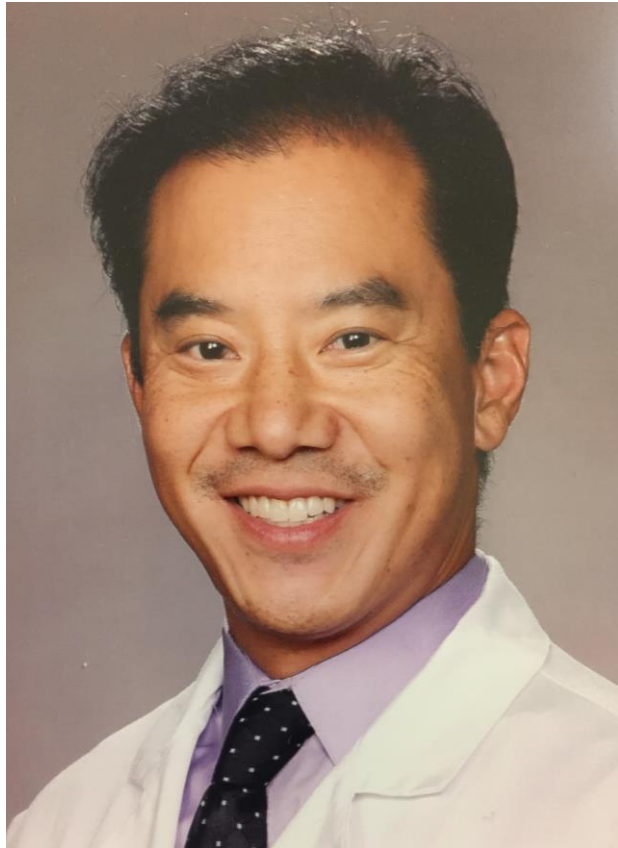
Relias courses are designed to help nurses and physicians avoid adverse events, including maternal mortality and litigation risk



**“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

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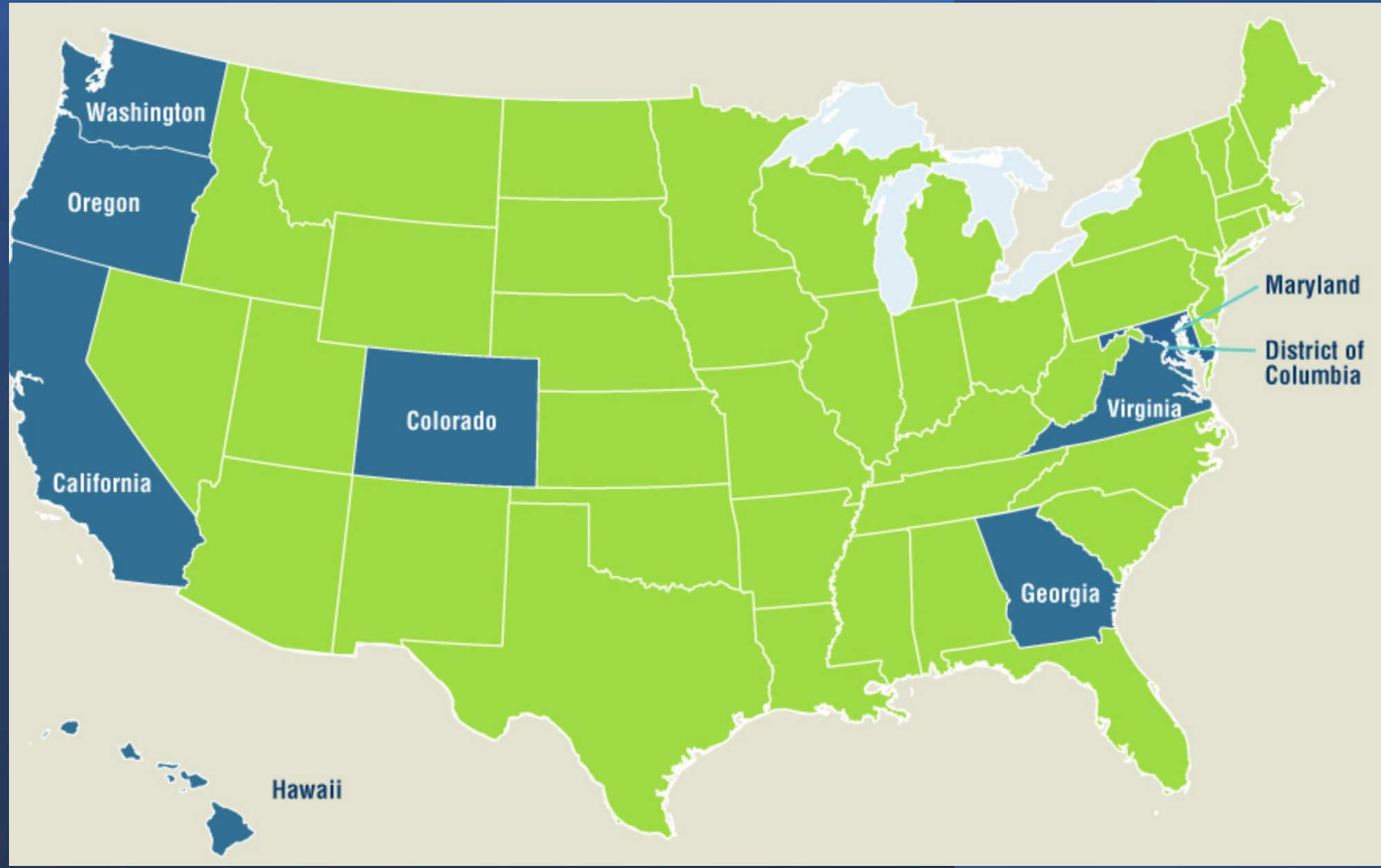
## Participants will..

- 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”

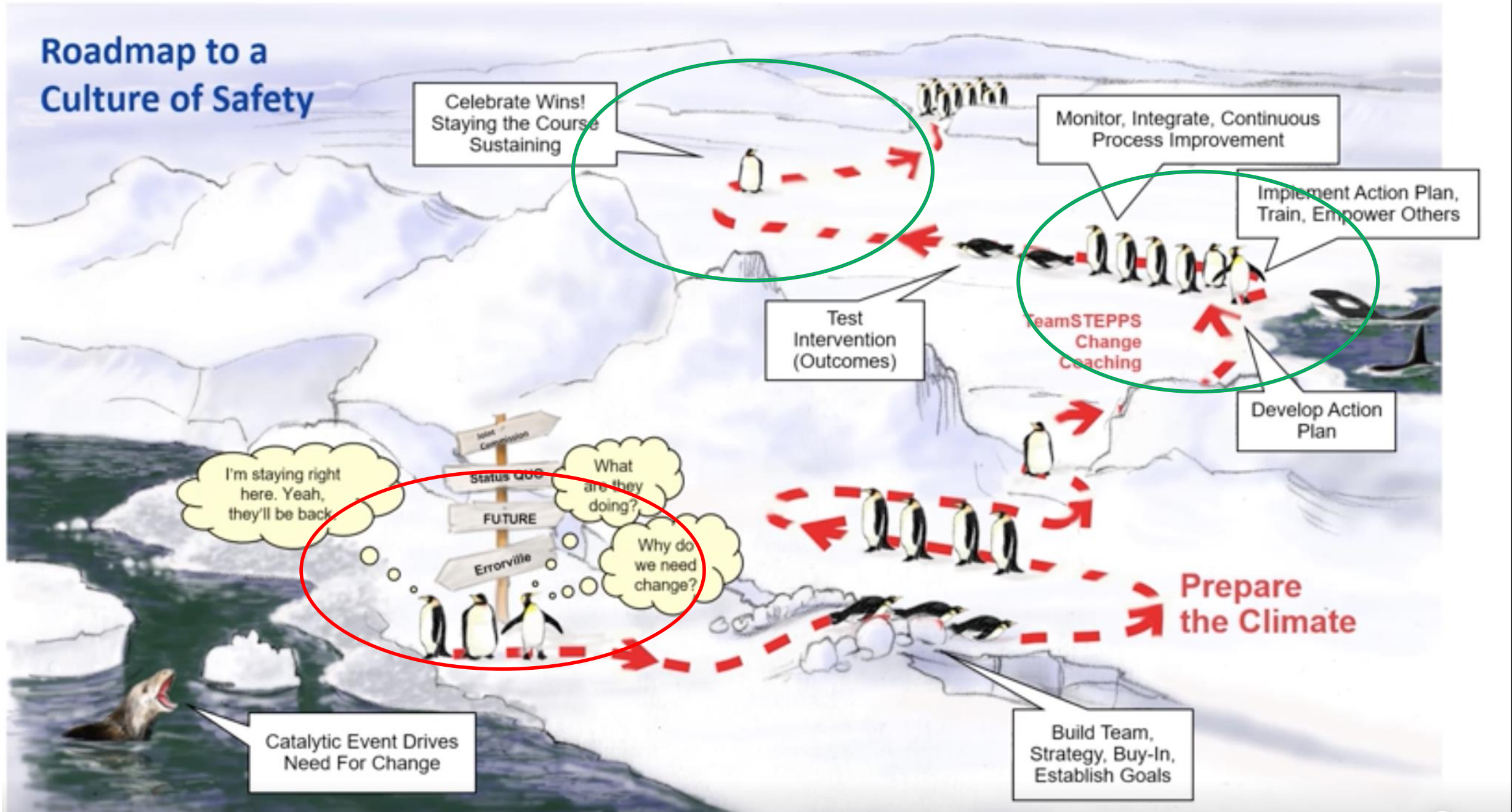
Not these few...







# Roadmap to a Culture of Safety



*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.

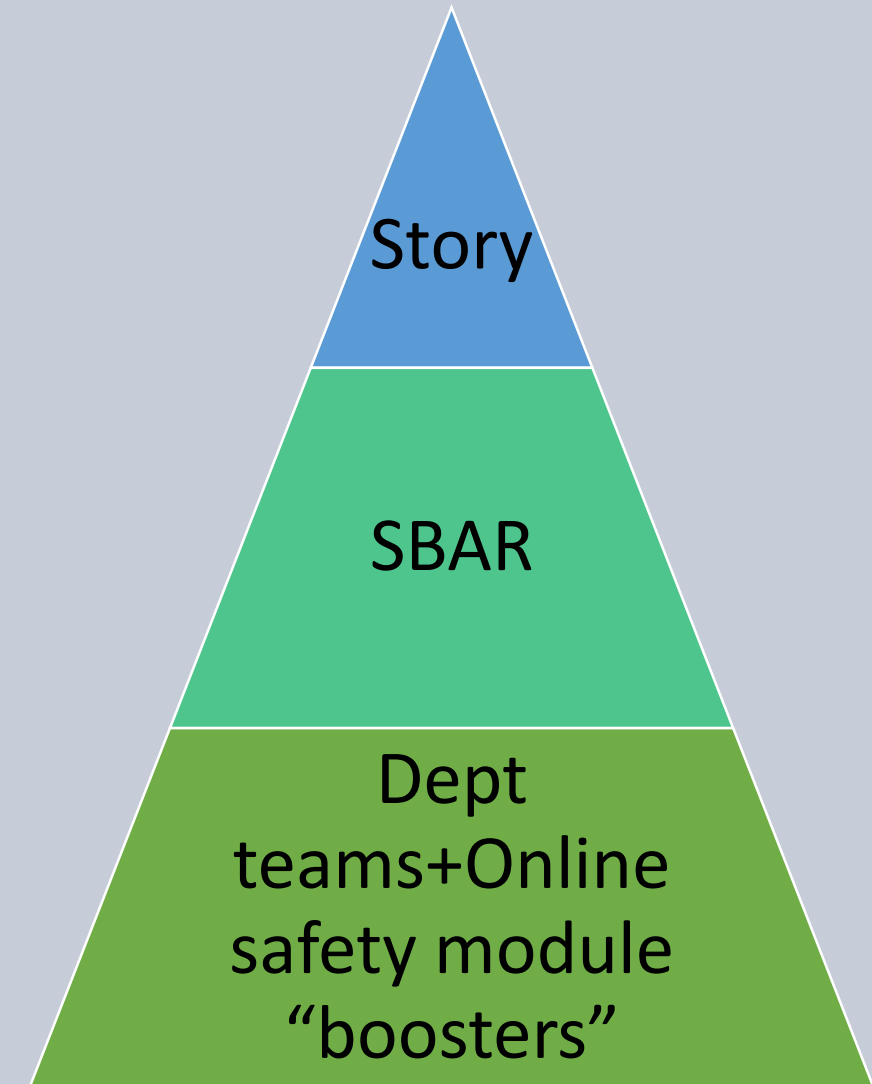
**B** – The patient had multiple lesions on his back and the lesion that was to be excised on the day of surgery was misidentified. The patient and a family member were part of the procedure verification and they had pointed to the incorrect lesion. Once this was identified as the incorrect lesion, a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

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

5yPost Interactive Video Player


apiplayposit.com/player\_v2?type=bulb&bulb\_id=1022108&section\_id=1007462

Nonverbal communication can be just as powerful as verbal communication. When someone on the team does speak up, what effect does the leader's 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



HRST  
leader's response dictates the culture of the room

Reply

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

KA Keith R. Aeron 1:15 PM  
rushed

Vincent J Cheung 1:15 PM  
Devalues time out process

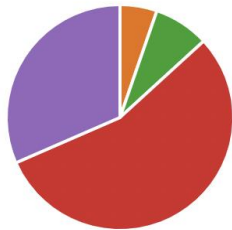
Recording has started

# Build a system of feedback from your audience

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

[More Details](#)

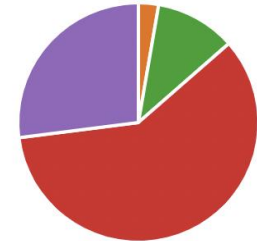
Strongly Disagree	0
Disagree	2
Neutral	3
Agree	21
Strongly agree	12



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

[More Details](#)

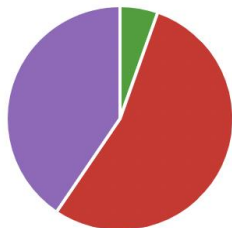
Strongly Disagree	0
Disagree	1
Neutral	4
Agree	22
Strongly agree	10



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

[More Details](#)

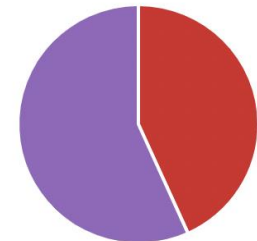
Strongly Disagree	0
Disagree	0
Neutral	2
Agree	20
Strongly agree	15



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

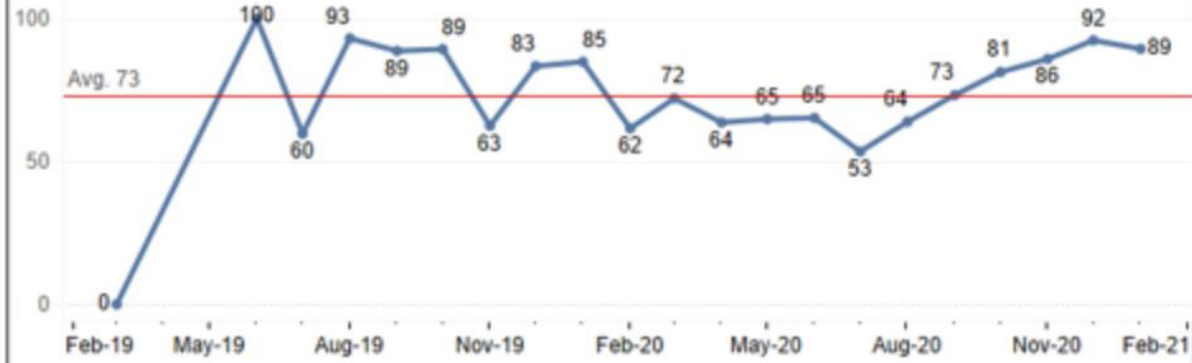


# Data helps support your story

## Situation Monitoring

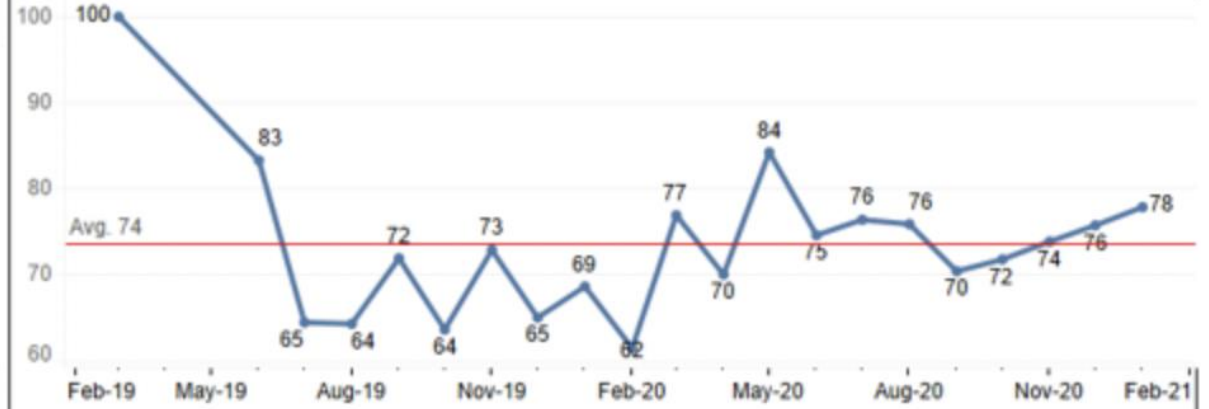
- 1 - Team Attire
- 9 - Dry Time
- 10 - Fire Assessment & Team Plan
- 11 - Burn Risk Assessment
- 14 - Sterile Environment & Medication Labeling

*New Questions*



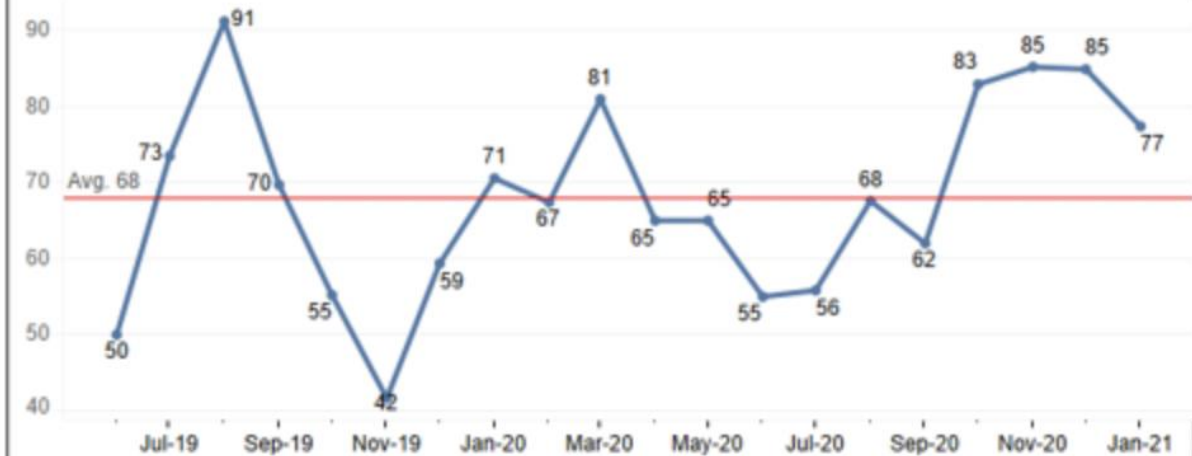
## Mutual Support

- 4 - Verification: Patient Information
- 5 - Verification: Procedure Consent
- 15 - Pre-Incision Time Out: Leadership



## Communication Index

- 6 - Verification: Site/Side
- 7 - Verification: Graft/Implants
- 8 - Verification - Confirmatory Studies



## Leading Teams

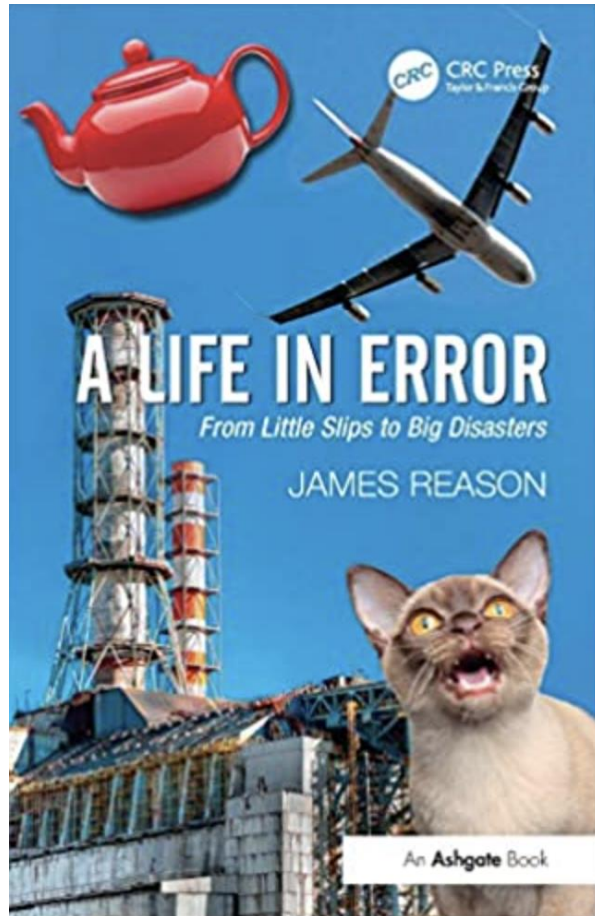
- 2 - Briefing: Team Engagement
- 3 - Briefing: Introduction
- 12 - Leadership
- 13 - Pre-Incision Time Out



The image features a landscape with a dark blue sky and a white foreground, possibly snow or a bright field. The text "Reason with Swiss Cheese..." is centered in the middle of the image in a white, sans-serif font.

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 MAKE A MISTAKE  
IS HUMAN, BUT TO  
BLAME IT ON SOMEONE  
ELSE, THAT'S EVEN  
MORE HUMAN.**

*Cool Funny Quotes.com*

**SAY NOTHING**

**THEY'LL BLAME THE DOG**

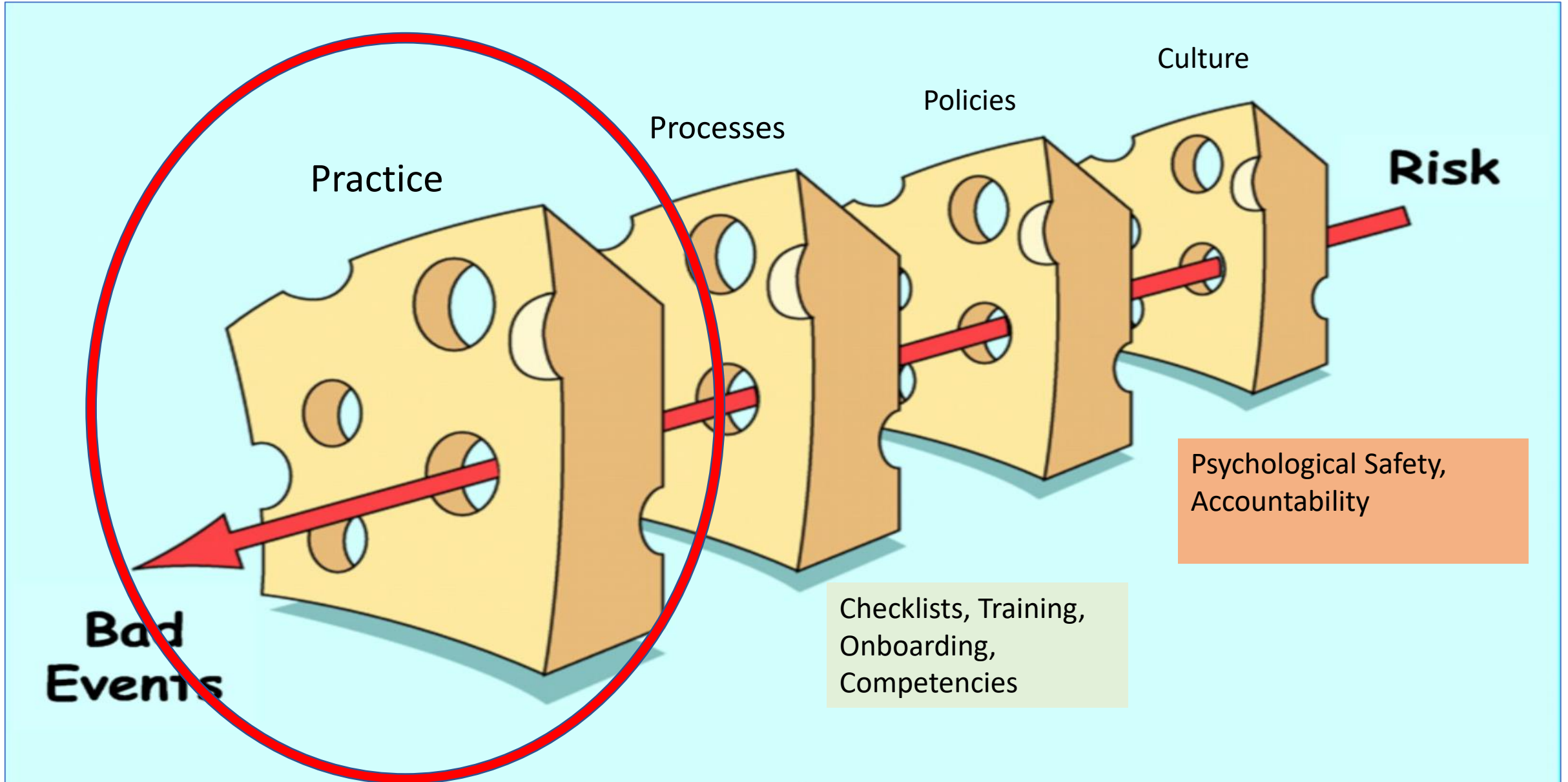
# TO ERR IS HUMAN

- 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



Practice

Processes

Policies

Culture

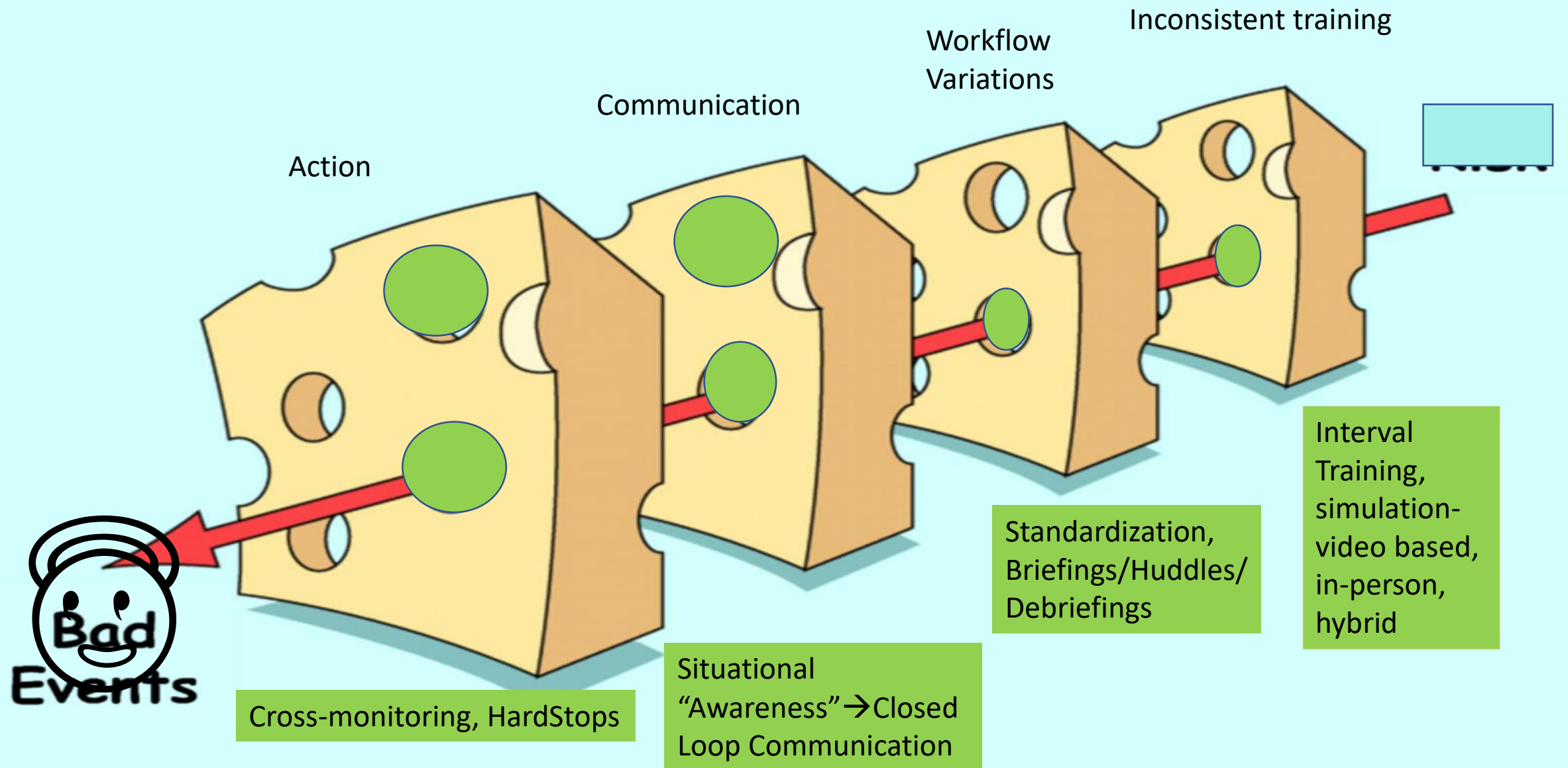
**Risk**

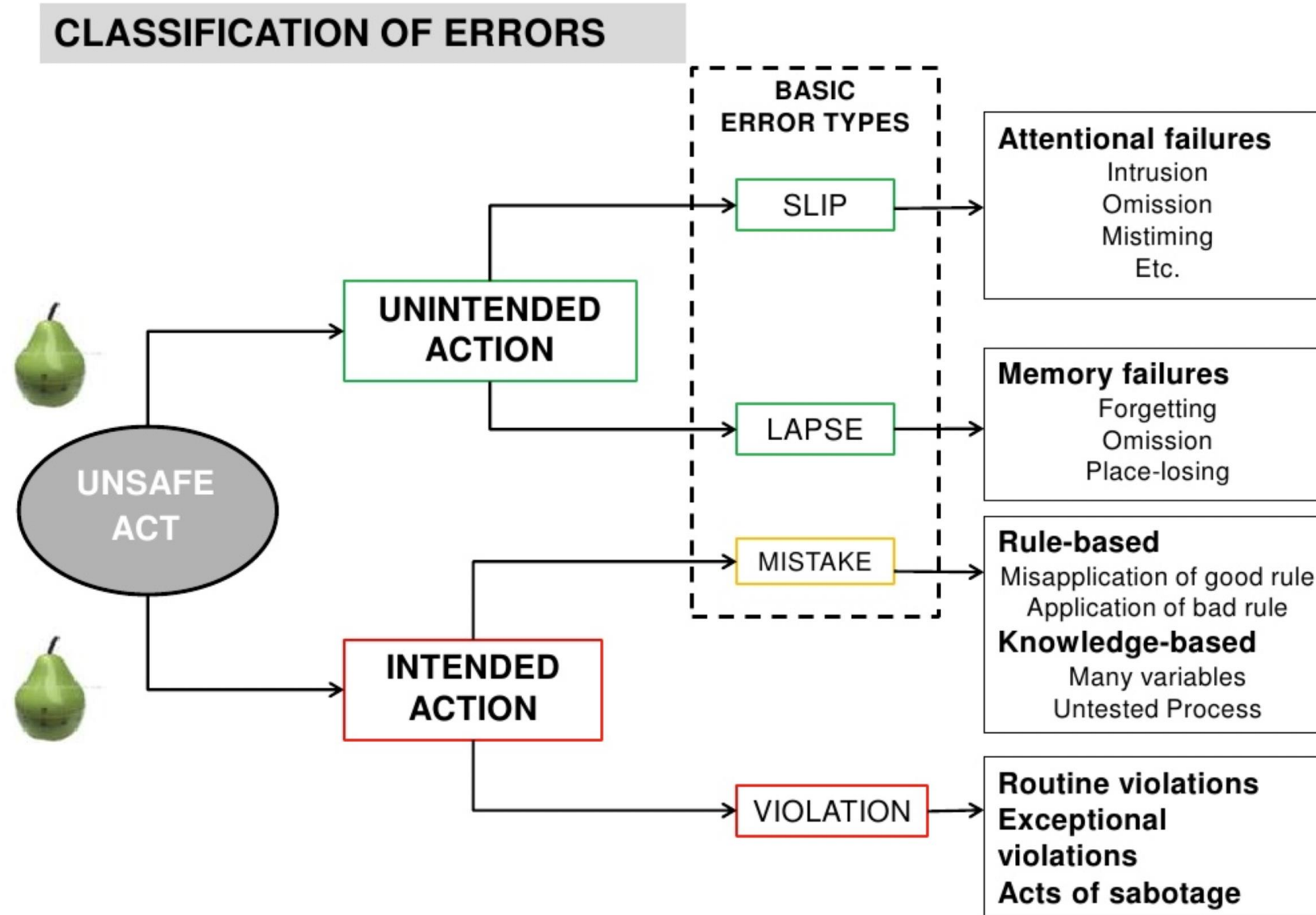
**Bad  
Events**

Checklists, Training,  
Onboarding,  
Competencies

Psychological Safety,  
Accountability

# Active Failures--Practice Slice





The image features a background of a forest with a dark blue horizontal band across the middle. The text is centered within this band.

Identify near misses and promote good catches

# FROM ERROR TO RESILIENCE

Model  
LEADERSHIP

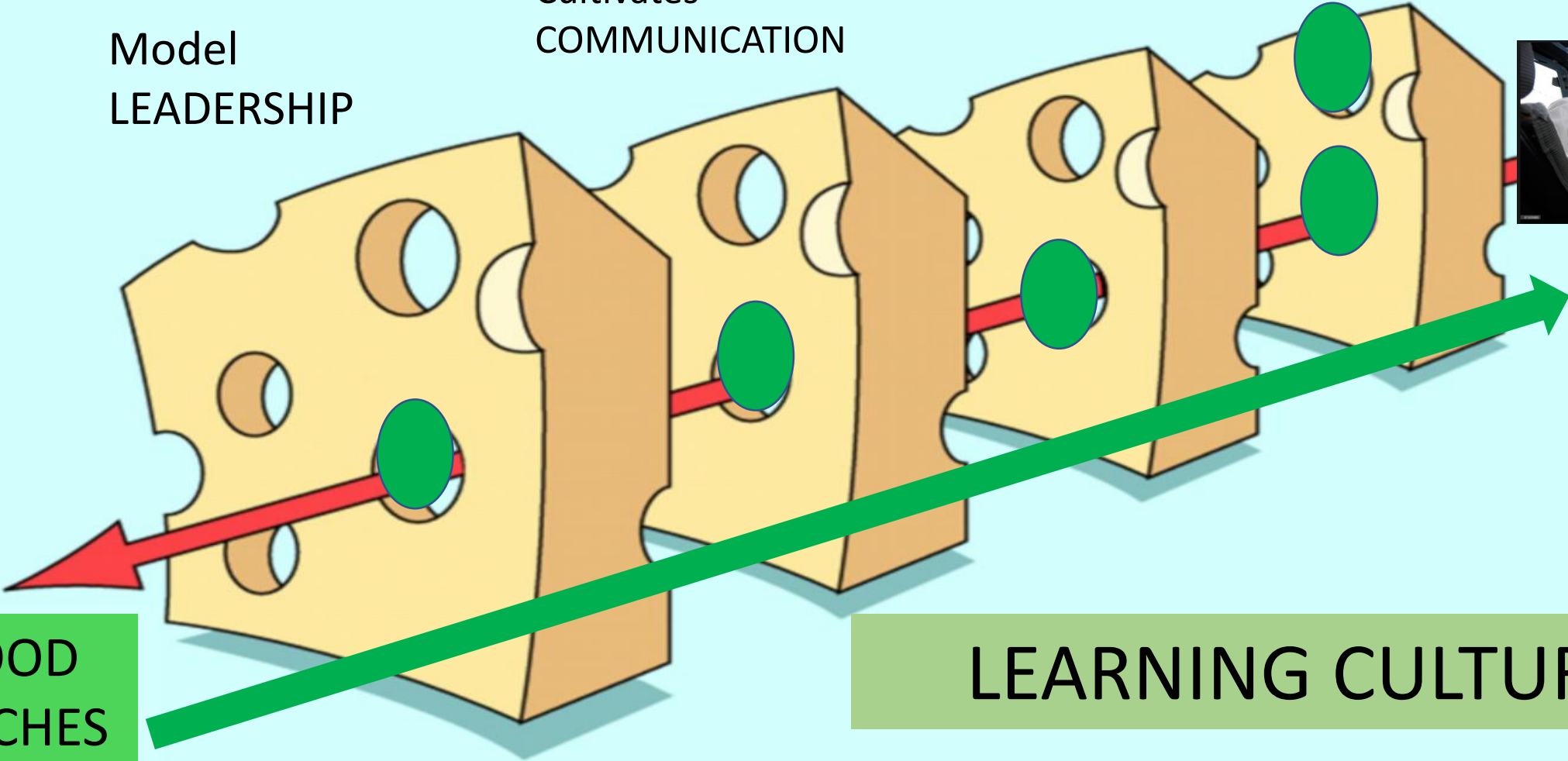
Cultivates  
COMMUNICATION

Enhance  
WORKFLOWS/Polices



GOOD  
CATCHES

LEARNING CULTURE





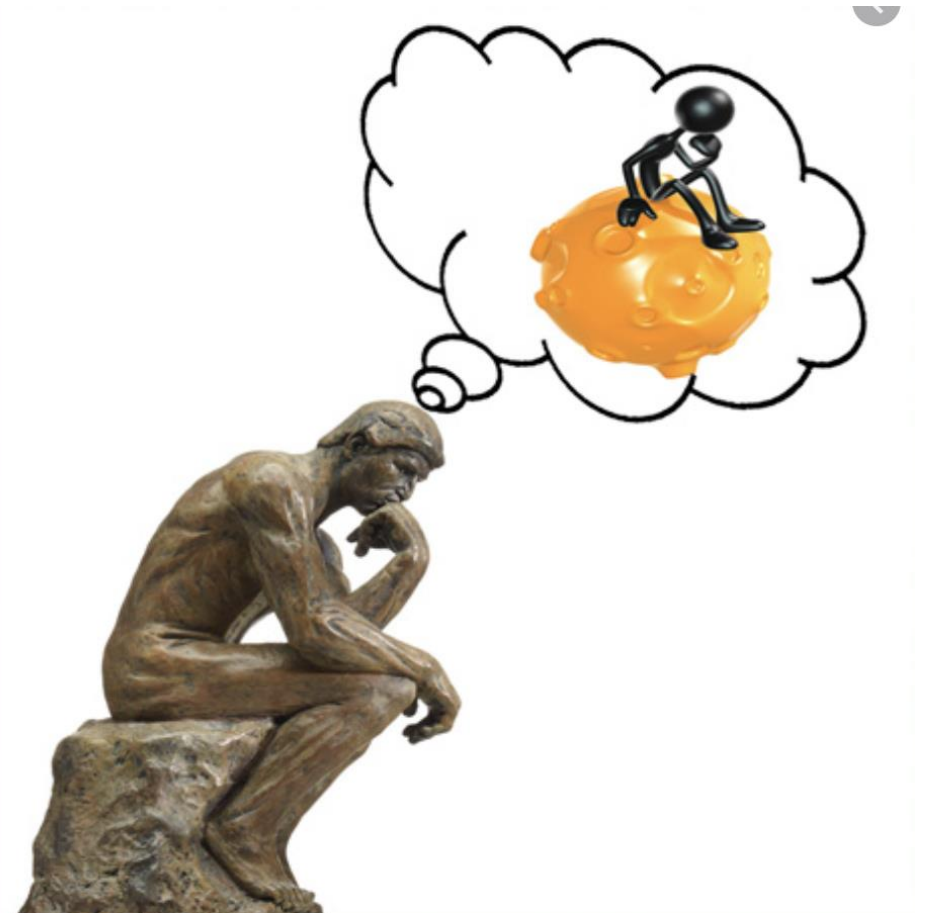
Taking a deeper dive...

# 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

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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.

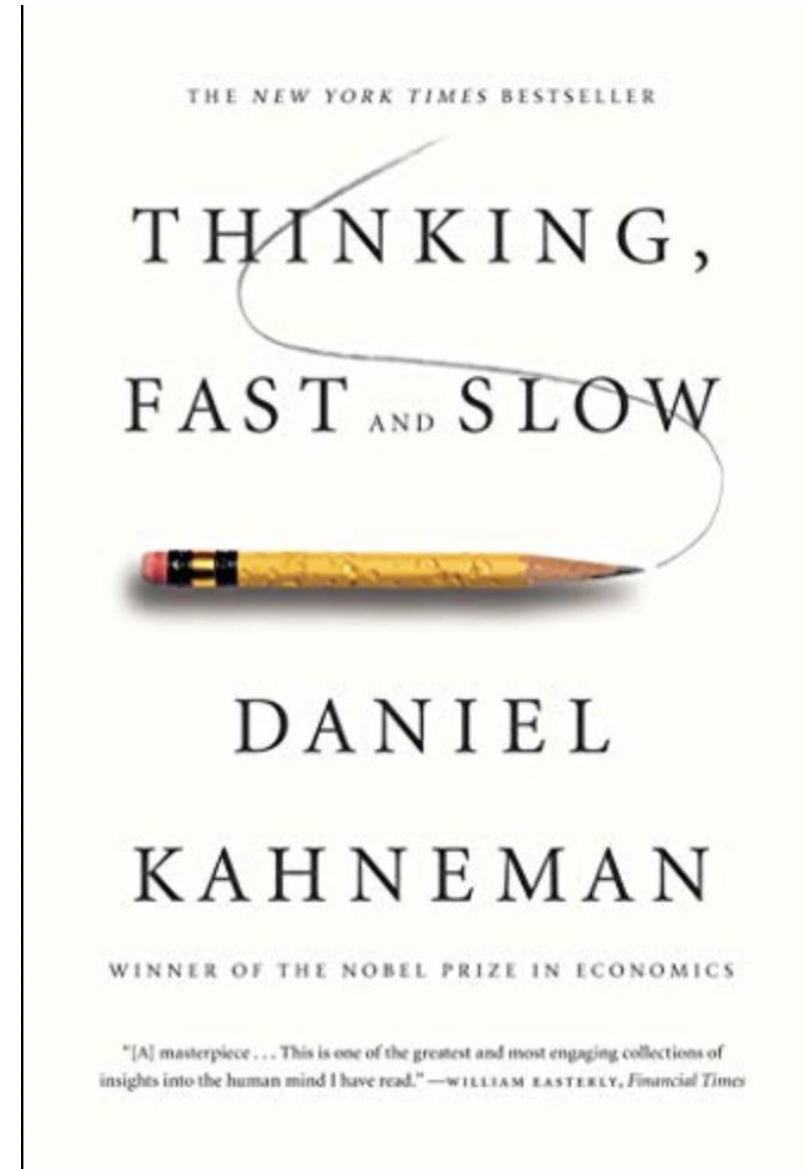
Although the extent to which such cognitive processes play a role in anesthesia practice is unknown, anesthesia care frequently requires rapid, complex decisions that are most susceptible to decision errors. This review will examine current theories of human decision behavior, identify effects of nonrational cognitive processes on decision making, describe characteristic anesthesia decisions in this context, and suggest strategies to improve decision making. (**ANESTHESIOLOGY 2014; 120:204-17**)

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**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”)





**MICHAEL KANTER, MD**  
Professor and Chair of Clinical Sciences, Kaiser Permanente School of Medicine  
Associate Investigator, SCPMG Department of Research and Evaluation

Why talk about diagnostic errors?  
Michael Kanter, MD CPPS



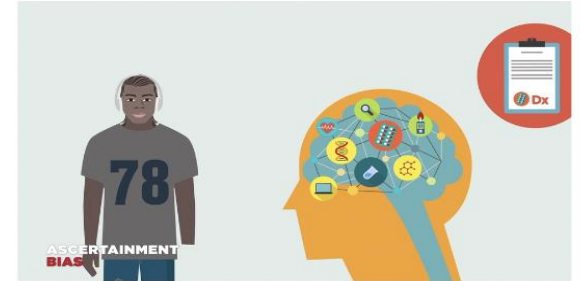
Partnering with patients to drive diagnostic excellence  
Susie Becken, Patient Advocate



**HOW COMMON ARE DIAGNOSTIC ERRORS?**

**LAWRENCE LURVEY, MD JD**  
Regional Assistant Medical Director of Quality, Risk, Regulatory Services, and Maternal Child Health, SCPMG

Avoiding diagnostic errors  
Lawrence Lurvey, MD JD



Understanding bias



**IF YOU HAVE A BRAIN YOU HAVE BIAS**

**SHARI CHEVEZ, MD**  
Physician, Co-Lead SCAL Equity, Inclusion, and Diversity, SCPMG

Self-awareness of unconscious bias  
Shari Chevez, MD



**COGNITIVE BIAS CAN LEAD TO INACCURATE DIAGNOSES**

**KIM TRAN, MD**  
Regional Assistant Medical Director for CME, SCPMG

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



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



**CREATE LINES OF COMMUNICATION WITH BACK OFFICE STAFF**

Back office teamwork  
Aileen Oh, MSN RN



**COGNITIVE BIAS CAN OVERSHADOW A TRUE DIAGNOSIS**

Raising your diagnostic awareness  
Ronald Loo, MD



**WILLIAM STRULL, MD CPPS CIP**  
Medical Director, Quality and Patient Safety, The Permanente Federation

A physician's perspective  
William Strull, MD CPPS CIP



**ENHANCING DIAGNOSTIC RELIABILITY**

- Being alert to cognitive biases
- Engaging your patients and health care team
- Always make and document a differential diagnosis

Systems to achieve diagnostic excellence  
Tracy Jones, MD



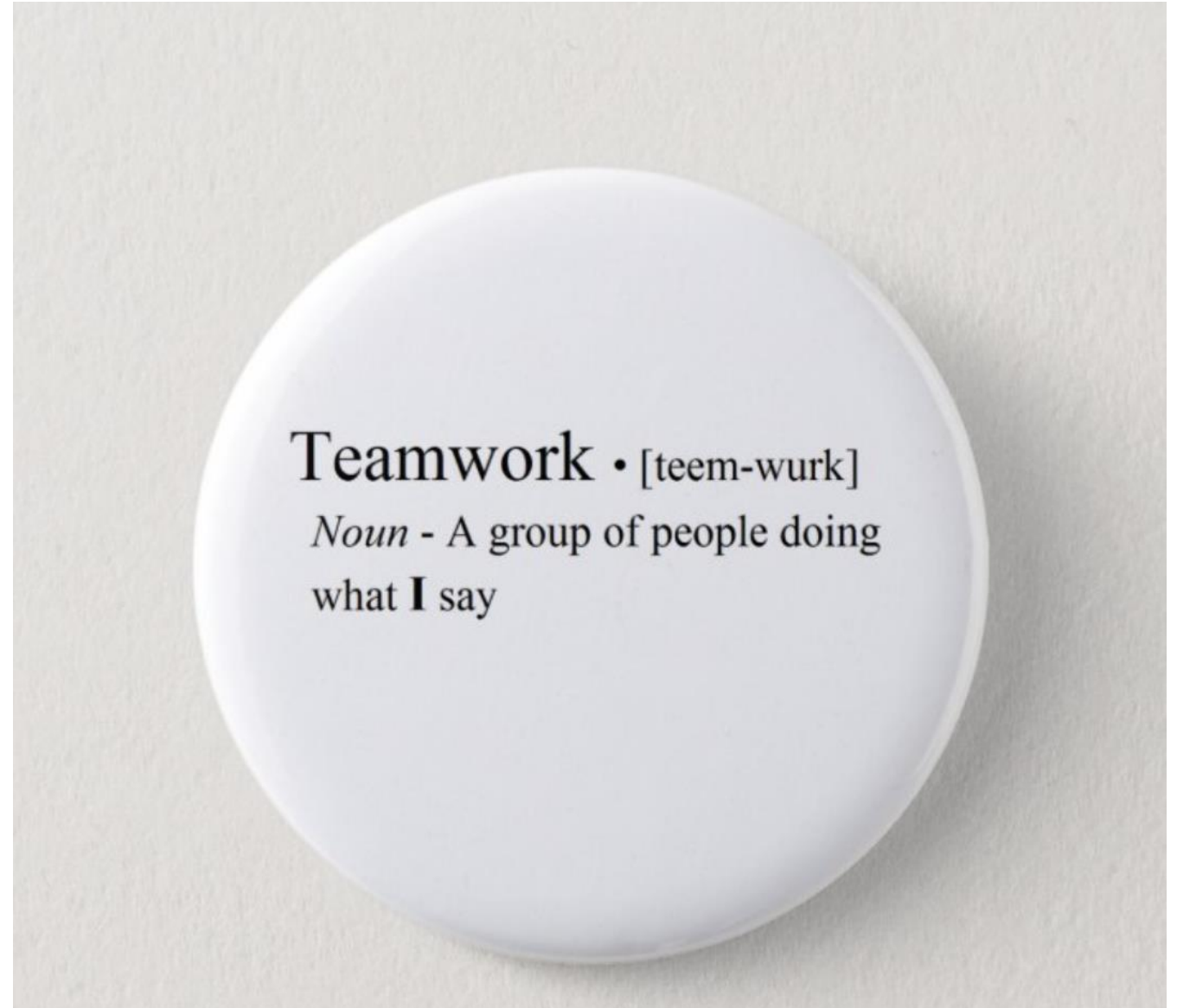
**TeamSTEPS® PROVIDES KEY TOOLS AND STRATEGIES FOR:**

- Communication
- Situation monitoring
- Mutual support
- Leadership

Tools for patient safety  
Vu Nguyen, MD

From individual awareness to  
Team awareness

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



## KLM. From the people who made punctuality possible.

Building an airline of KLM's standing requires a special kind of dedication. Like making a pair of being punctual. A quality that every Dutchman has.

It was Christian Huygens after all, who gave it its significance - when he invented the spring balance that made accurate timekeeping possible. A custom without which life is inconceivable. It is true, for that matter, that one can illustrate that singular Dutch ability for doing things well. As you'll discover when you fly KLM. You'll find your host warmly responsive, if not effusive, punctual and friendly understanding.

For that is the way the people of Holland see. People who understand that KLM is the reliable international airline. As your travel agent will confirm.



And any of Holland's long-making and precise in the old tradition. In this time-honored process, legs are split, hollowed, shaped, smoothed and ultimately transformed into the article well-known in many parts of the country.



A right word here is what you have in KLM's Royal Class service. A personal and generally Dutch to welcome is always extended with a choice of what different courses. But that's the only in keeping with that which can be seen good to be served just food.



**KLM**  
The reliable airline of those surprising Dutch.



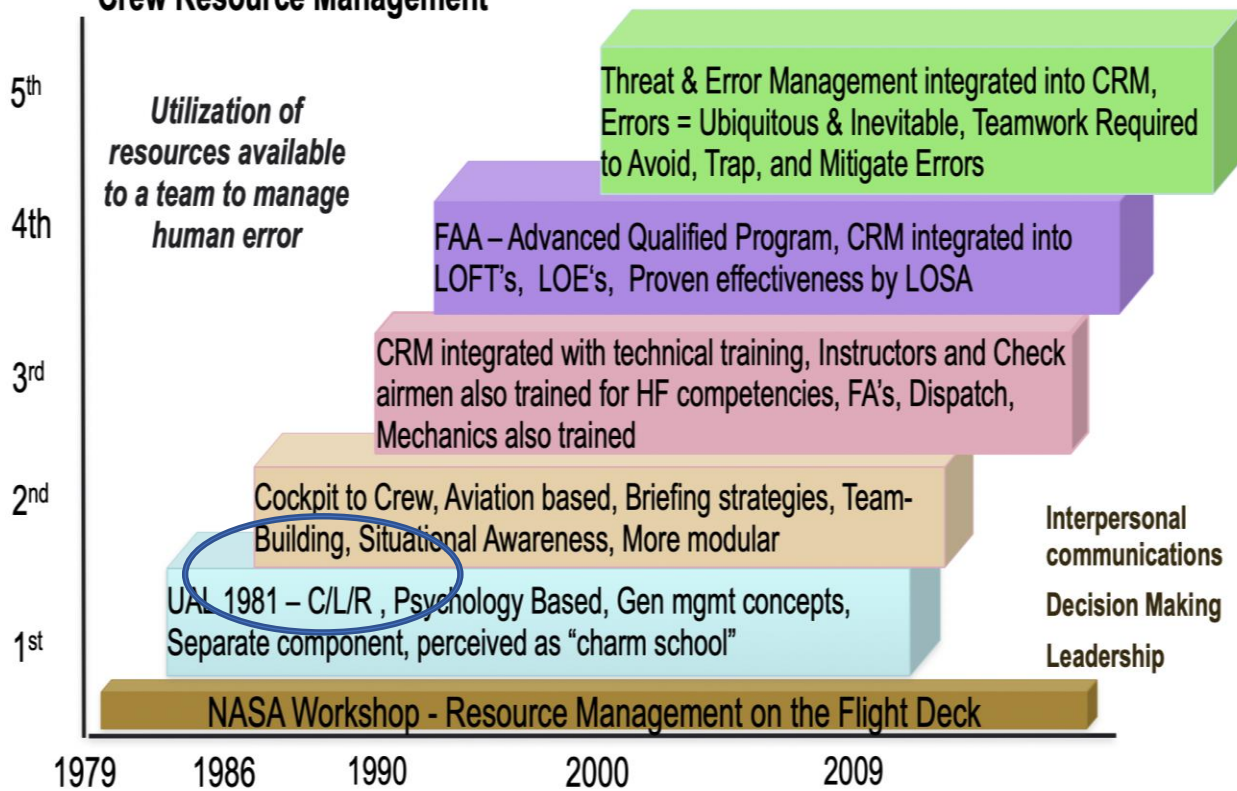
<https://youtu.be/2mnuQkmywrc>



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



## Crew Resource Management



**UNITED AIRLINES**  
**C/L/R Toolkit**

The **CAPTAIN** remains in charge. This guide empowers **ALL** crew members to speak up on **ANY** issue before, during, or after a flight. It is a tool to encourage discussion, as communication can resolve problems.

**AS YOU ASSESS YOUR FLIGHT, REMEMBER - SOMEONE MUST FLY THE AIRPLANE!**

Were you uncomfortable? Was there conflict? Was communication strained? If so, mention this NOW! Do not keep it inside.

Were you ignored? Was input rejected? If so, express concern NOW! Be tactful, but assertive. Do not let this issue pass.

Were all decisions made? Did you listen to all input? Use this model to make a decision after an event:

Identify Problem → Propose Solutions → Choose The Best → Execute Action → How'd We Do? → **RESOLVED**

New Cues →

Were all problems defined? Was something wrong but not discussed? If it bothers you, look again!

Were you rushed? Were you overloaded? Was there confusion? Use this model for Workload Management:

**PLAN → PRIORITIZE → SEQUENCE → ASSIGN**

Did you learn something? Share this with the rest of the crew. Include compliments as well as suggestions.

Was someone in charge?

Be especially alert if you hear: "What's It Doing Now?" "Where Are We?" "No Problem!" "Is This Safe?" "Looking Good!" ". . . Behind! . . . Rushed! . . . Late! "Watch This!"

**C/L/R HAS TAUGHT FLIGHT ATTENDANTS THE ELEMENTS OF INQUIRY AND ADVOCACY. LISTEN FOR THESE AS WELL AS THE "CUS" WORDS: "Concern!" "Uncomfortable!" "Safe!"**

See FOM for more descriptions. © Copyright 1999





*“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”*

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See FOM for more descriptions. ©Copyright 1999



“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](mailto:jason.y.cheng@kp.org)



**Questions? Stay in Touch!**

[www.aha.org/teamtraining](http://www.aha.org/teamtraining)

Email: [teamtraining@aha.org](mailto:teamtraining@aha.org) • Phone: (312) 422-2609

