Implementing Team-Based Care: It's Our Duty

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Healthcare personnel are human, and subject to error. Threats to patient safety happen. Enhanced team-based care can help to decrease errors. This will require effective communication, the elimination of hierarchy, as well as a culture that acknowledges and anticipates errors.

A four-year-old boy with planned surgery for a wandering right eye mistakenly undergoes surgery on the left eye. A nursing home patient with Alzheimer's is found dead in a closet into which she wandered and became trapped. A 19-year-old dies from an air embolus as a result of improper removal of a central line. These are just a few examples of medical errors reported in a CNN article entitled "10 shocking medical mistakes."¹

While the events are undeniably tragic, the hidden misfortune behind a report like this is the way in which medical errors are reduced to being consequences of a single person's actions. Finding a scapegoat is simple and gratifying in the face of trying to make sense of tragedy, but would it not be more effective to use every error as an opportunity to change the system for the better and thereby prevent future errors? Tragedy should inspire thoughtful questions and motivate us to generate appropriate solutions. For example, at the institution where the four-year-old's wrong site surgery took place, is a "time out" routinely done? Were operating room team members well informed about the surgery and what was expected of them pre-procedure? Did all of the people involved (from

“Healthcare is so fragmented and difficult to understand; we need facilitators to help and advocate for their needs.”

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attending surgeon to medical student to circulators) feel a part of the team and hence empowered to speak up and/or stop the line? The term “stop the line” originates from the TOYOTA manufacturing company who developed a system in which any person on the assembly line could push a big red button if they had any concern, and stop production until the concern was resolved. While the natural worry is this will decrease productivity, they found it dramatically increased safety and even quality. In a similar fashion, we need our healthcare teams to be empowered to do the same! Does the nurse who improperly removed the central line work in a hospital that instituted policies detailing how nurses should care for every type of line and educate them on the complications of removal? We are wrong to believe that a single well-meaning provider has the sole responsibility for the death of an individual when his or her success as a provider is largely dependent on the culture of the workplace and the nature of the collaboration that takes place between members of the medical team.

Creating a culture that encourages open communication and reporting of errors has been part of the effort to reduce systematic deficiencies leading to errors. Ultimately, this “culture of safety” strives to shift attitudes away from a hierarchical system of perceived infallible leaders and blaming individuals toward identification of errors as defects of a faulty system and understanding that “to err is human.” The cost of medical errors is twofold: lost lives and monetary loss. Preventable errors cause 44,000–98,000 deaths in the United States annually,^{2,3} with an associated cost of \$17–29 billion.⁴ One could argue that reduced team morale is a third cost of medical errors. Without a system in place designed to address why an error occurred or to alleviate concerns of the individuals involved, future patient care will be compromised and the cycle of medical errors will continue.

Before strategies for modifying the culture of healthcare can be implemented, barriers to doing so must be identified. Communication has been identified as the most important component to safe healthcare delivery. Barriers to efficient communication arise from a number of sources—educational, psychological, and organizational.⁵ **Weller et al.** believe that effective communication begins with undergraduate medical students who are often not taught how to communicate with other health professionals.⁵ The psychological component stems from the “tribal phenomenon,” in that people relate to their own profession and are less inclined to trust others. Finally, the organizational barriers to communication involve technical difficulties in coordinating patient care among all the providers and all the variables involved in the patient’s care. Several additional barriers to communication stem from the different ways nurses and doctors are taught to communicate.⁵ Since nurses are generally not taught to make diagnoses, they are instructed to be very broad and narrative in their description of clinical

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situations. This is in contrast to physicians who are taught to be concise with their descriptions, having already come up with a differential diagnosis. Key differences like this are why communication tools such as “SBAR” have been developed, which creates a uniform language for relaying information that diversely trained individuals can understand. Using SBAR,⁶ each clinical scenario is broken down into the (1) Situation—what is happening with the patient; (2) Background—describing the clinical background; (3) Assessment—what is considered to be the problem; and (4) Recommendation—what should be done to correct it. Using this format facilitates organized briefings before shifts and serves as a language that providers can use to communicate efficiently and effectively. The medical hierarchy is also discussed as an impediment to communication. It is not conducive to healthy team functionality when individuals do not feel safe speaking up when they see something wrong. Lastly, there is a shared cultural belief in medicine that says that quality of care and error-free clinical performance are the result of being well trained and of hard work. As a result, mistakes are viewed as personal failure and therefore are never discussed openly and acknowledged as a reality.⁶

Successful strategies to improve team-based care will therefore be those that address three objectives: improving styles of communication, breaking down the medical hierarchy, and establishing a cultural belief that recognizes mistakes are inherent to human nature. Time outs, checklists, SBAR utilization, surgical site marking, and other similar initiatives are important additions to the communication strategies. Furthermore, we can draw from several clinical initiatives that have applied these principles in hopes of doing just that. KAISER PERMANENTE has been quite proactive in implementing strategies that promote a culture of safety. It has standardized SBAR as the main source of communication, and uses it at all shift changes and debriefings. At ORANGE COUNTY KAISER, perioperative briefings were instituted as a way to promote accountability and encourage dialogue among OR staff. Prior to the procedure, the surgeon, circulating nurse, scrub nurse, and anesthesiologist discuss what they will need to know in order for the surgery to be successful. Since then, wrong site surgeries have not occurred, nursing turnover decreased by 16%, and employee satisfaction has increased by 19%.⁶

Recognizing that the demands of obstetrics and gynecology can challenge even the most skilled physicians, the BRIGHAM AND WOMEN’S HOSPITAL perinatal unit initiated “board” rounds (or labor and delivery unit rounds), expected of all nurses and physicians covering the obstetrical unit. This created a space to discuss patients openly, receive input regarding the care plan, and freely express concerns. It is essentially an open forum that nurses can use to advocate for their patients without fear of repercussions.⁷

With **SBAR**, clinical scenarios are broken down into:

Situation: What is happening with the patient?

Background: Describe the clinical background.

Assessment: What is considered to be the problem?

Recommendation: What should be done to correct it?

The AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ) contracted with BOSTON UNIVERSITY MEDICAL CENTER to develop a set of tools and assist hospitals to implement the “re-engineered discharge plan” (RED). This is an initiative that utilizes a team-based care framework to improve patient safety. It has the additional benefit of mitigating the cost of healthcare by ensuring that all discharged patients understand how to care for themselves in the days after discharge in order to prevent readmissions. This is a multidisciplinary approach to a complex mission. It necessitates cooperation among representatives from diverse constituencies of the hospital, including patient safety, nursing, physician leadership, case management, hospital administration, pharmacy, patient educators, information technology, chaplains, and interpretive services as needed.⁸ One study recruited 10 hospitals to implement RED, and the findings were discussed. Eight out of 10 hospitals reported improvement in 30-day readmission rates after RED implementation. Not surprisingly, leadership and multidisciplinary implementation teams were key to their success.⁹ In particular, two Texas hospitals saw all-cause readmissions drop from 23.3% and 26% to 15% after just one year of implementing RED.¹⁰

Evaluating our nation’s progress in the area of patient safety will require us to ask ourselves the following: has the shift away from individual blame toward a team-based acceptance of responsibility had any impact on the culture of healthcare? Are patients safer as a result? Have healthcare costs been positively influenced? In a 2014 report from the AHRQ, hospital care was shown to be safer in 2013 than it was in 2010, with 17% fewer harms to patients and 1.3 million fewer hospital acquired conditions. Additionally, from 2011 to 2013, there were 50,000 fewer hospital deaths as a result of the reduction in healthcare-acquired conditions (HACs), and \$12 billion in healthcare costs were consequentially saved over those three years. The rate of HACs is still high, however, with an estimated 121 HACs per 1000 discharges.¹¹ Nonetheless, there has been substantial progress toward improving safety and lowering costs.

The AHRQ was designated as the lead agency in supporting federal research efforts to reduce medical errors by the Healthcare Research and Quality Act of 1999, and it has done significant work to raise awareness and support patient safety projects, some of which were mentioned previously. Improving upon what has already been done will necessitate the help of this agency. The emphasis should continue to be on building a culture of safety and breaking down hierarchy. As effective communication is at the foundation of team-based work, it is a skill that should be heavily emphasized at the student level.

At the READING HOSPITAL, we have implemented a simple phrase: “fill me in.” This phrase can, and should, be used when someone

“Eight out of 10 hospitals reported improvement in 30-day readmission rates after RED implementation.”

notices a team member doing something that could lead to harm or error. It is a noteworthy phrase, which can be used in front of the patient and should be interpreted as “I have a concern.” The team member should use this as an opportunity to clarify communication and discuss concerns. If they don’t, the person with a concern should simply use words from the mnemonic “CUS”, which stands for Concern, Uncomfortable, and Safety. They can calmly say, “I have a safety concern,” “I feel uncomfortable,” or “this is a patient safety issue.”

The UNIVERSITY OF VIRGINIA has also taken a lead on safety initiatives with inter-professional education workshops for third-year nursing and medical students. These workshops utilize standardized patients to simulate clinical scenarios, including management of critical illness in the ICU, how to carry out difficult conversations at the end of life, and managing chronic illness. By working together in simulated settings to manage these patients, the students can see what will be required of them as nurse or doctor, learn about clinical guidelines, and gain teamwork skills.¹² This is a unique approach to reducing the medical hierarchy that often hinders open communication between physicians and other healthcare providers. As such, there is a great value in encouraging large universities with both medical school and

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nursing programs to implement workshops such as this in their curricula. If students are taught the ideal culture of medicine, they will go to patient care areas with this vision in their minds. They will have the ability to recognize barriers to teamwork and be inclined to fix rather than tolerate them.

Another intervention could include the creation of special hospital committees designed to analyze errors and generate solutions on how to prevent future mishaps. Patients who are directly affected by the errors should be active participants in the discussion.¹³ It will be an open dialogue where patients, their families, attendings, residents, nursing supervisors, charge nurses, staff nurses, and licensed practical nurses will be invited to share their version of the events leading up to the error with ideas on how it could have been prevented. Special attention must be given to avoid blame, which is where a skilled moderator will be very useful in facilitating discussion and guiding the participants to a useful solution.

It is important to recognize that establishing a culture of safety is dependent on the support of physicians and others involved in patient care. In the aviation industry, where a culture of safety has been successfully implemented, the captains actively encourage novice pilots and other team members to speak up if they notice a concern. For obvious reasons, a young trainee will be less likely to speak up if he or she doesn't perceive that their superior is receptive to the idea. In other words, this must be a top-down philosophy and expectation. When people verbalize a concern, we need to praise them intentionally, especially if the concern was not deemed present.

It is our hope that further awareness and continuation of the work that has already been accomplished will shift the perception of healthcare workers and that of the general population. Americans should be reading headlines about collaboration among nurses, doctors, and healthcare administrators to rectify errors, not about a fragmented system whose workers are making isolated mistakes completely uninfluenced by the system and the people around them.

Creating a culture of safety not only serves to improve hospital climates and reduce medical error, but has the added benefit of producing better health outcomes. A nurturing work environment fosters providers that are content and driven to deliver the best possible care, which thereby strengthens the patient-provider relationship. As a result, patients will feel more inclined to be compliant with their healthcare practices as they have trust for the system that is taking care of them,¹⁴ thus yielding improved health outcomes. Lastly, we should continue to cultivate strong leaders in the medical community that are passionate about a team-based approach to healthcare, as the success of our healthcare system is dependent not just on the medical expertise of our providers, but on their flexibility, their willingness to admit fallibility, ability to cooperate, and their desire to be a part of the greater healthcare team. ■■■

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