St. Francis

We care for life.

Utilizing Proven Methodologies to Implement a Cultural Change for Improved Patient Safety

CREW RESOURCE MANAGEMENT

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A Burning Platform for Culture Change

Objectives

Describe the innovative model used by our hospital to create and sustain a culture of safety

Identify an example of a tool (checklist) the presenting hospital used to improve communication in our operating room.

We all have "Moments of Truth"

Blunt Realization
No matter how well trained, motivated and professional, if humans are involved ERROR is inevitable...

But there are usually warning signs of impending error

So the question is ...

Will we speak up?

Burning Platform for Change - St. Francis Hospital

Significant number of surgical events in 2009

- RCA's conducted demonstrated that intimidation of staff in OR contributed to these events – staff afraid to speak up in the interest of safety
- Teamwork was crippled by poor communication

Another Burning Platform for Change - Aviation

1977 Tenerife / 586 Dead

The Search for a Solution

The Search for a Solution: 2009

- The Board of Trustees, Senior Leadership and Medical Executive Committee collaborated and set goals:
  - Search for a sustainable solution: cultural transformation
  - Reduce SSI, Mortality Rate and Sentinel Events: Improve patient safety
  - Commitment by Board, MEC and Administration to OWN the solution
  - Sought partnership with recognized experts in safety

Parallel with Aviation

Aviation		Healthcare
70 – 80% of airline accidents are related to interpersonal communications (Sexton & Helmreich, 99)	=	70 – 80% of medical mishaps are related to interpersonal interaction (Williamson et al, 93)

Aviation's Solution: Teamwork & Communication Through Crew Resource Management

CREW: Any team, group working toward common goal.
RESOURCE: Individuals, equipment, procedures, systems
MANAGEMENT: Specific behavioral skills to lead, communicate, decide, and catch errors before they have negative impact on outcomes.

2009 Miracle of the Hudson
100% Survival

Leadership

Components of Ultra - Safe Systems

Leadership Pledge

Leadership will

- Support you when you speak up in the interest of Patient Safety.
- Give a prompt response when you submit a Concern Report.
- Not allow ANY retaliation for Assertive Statements or Concern Reports.
- Give clear and concise policies and the training to support them.

It's About Mutual Commitment

We expect you to

- Speak up in the interest of Patient Safety with an assertive statement.
- Submit Concern Reports when you see issues we need to address.
- Live by the team training principles and treat others with respect.
- Engage in training and follow policies and procedures.

From (INDIVIDUAL)	To (TEAM)
Single focus (clinical skills)	Dual focus (clinical & team skills)
Teamwork - loose concept	Teamwork - clear understanding
Individual performance	Mutual Support - Team goals
Unbalanced workload	Managed workload
Having information	Sharing information
Self-advocacy	Patient advocacy
Self-improvement	Team improvement
Individual efficiency	Team efficiency
Under-informed, individual decisions	Informed & collaborative Team decisions

Culture Shift

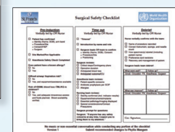
Crew Resource Management = Teamwork

Tools of Crew Resource Management

Teamwork Training Elements

- **Briefings**
- **Communication**
- **Cross check**
- **Assertion**
- **Decision Making**
- **Debriefing**

It's About Hardwiring Via Tools: Checklists



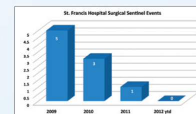
SFH Proven Results

Staff Feedback Post Implementation

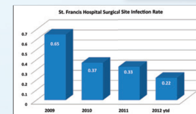
- We used to confirm that we had the right patient, the right side, the right procedure and the right supplies, but now there is a discussion before and after the case. The debrief is just as important as the prebrief. **It gives you something to build on next time and hopefully do it better.**
- **The communication has gotten better since we have used the safety training.** One of the difficult surgeons, when he gets frustrated now, he'll break scrub and leave the room for a minute and you can question him more now.
- I was part of that process where we developed concern reports and a pre-op to nurse handoff which is in every bay in pre-op. We have a nurse-to-nurse and anesthesia joins the nurse checklist in the bay. **We do a two-person, double-check.** In the room we developed two huge timeout boards.

Results / Outcomes

Safer Care



Better Outcomes



Lives Saved

Why Implement Crew Resource Management?

"The names of the patients whose lives we save can never be known.

Our contribution will be what did not happen to them.

And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been."

Don Berwick, MD, MPP, President and Founder IHI,
Former Director of the Centers for Medicare and Medicaid Services

Our Patients Are Counting on It.