Applying Crew Resource Management Principles to Healthcare

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Objectives

Participants will be able to:

1. Develop an understanding of how to use CREW methodology to reduce error and improve patient safety.
2. Discuss the value of using checklists.
3. Identify three innovative methods to minimize risk, and improve efficiencies utilizing the talents of all members of the healthcare team.
Why Hospitals Should FLY
The Ultimate Flight Plan to Patient Safety and Quality Care

John J. Nance, JD
Elements of Crew Resource Management

CRM is not a seminar or class; it is a way of life.
Factors Affecting Safety

• Hierarchy-cultural roadblocks to effective communication
• Fatigue-research suggests that there are negative effects on motor and cognitive performance
• Task saturation-myth of multitasking; according to researcher James Poldrack, “We’re really built to focus. And when we sort of force ourselves to multitask, we’re driving ourselves to perhaps be less efficient in the long run even though it sometimes feels like we’re being more efficient.”
Factors Affecting Safety con’t

• Role function-right people doing the right job; not performing tasks that are not associated with job responsibilities

• Distractions-starts and stops over and over again

• Standardization-different equipment, different provider preferences regardless of protocols and best practices, different patient care processes
Distractions and Interruptions

• Loud conversations
• Alarms
• Questions and requests from visitors
• Requests from physicians
• Phone calls
• Call lights
• Ambient noise
• Maintenance and housekeeping carts
Error Management Pyramid

- Mitigate consequences of error
  - Checklist guided assessment

- Trap error
  - Team monitoring

- Avoid error
  - Briefing

Applications to Healthcare

Leaders play a critical role in creating, sustaining, and changing culture through their own behaviors.
Leadership

“Leadership is about making others better as a result of your presence and making sure that this impact lasts in your absence.”

Harvard Business School

Building Teams
All together now.
Structured Communication

Above average performance—team members question leader’s decisions and actions.

Above average teams—member observes a potential error, they intervene.

Actions of team members are challenged and safety concerns asserted and expected.
Briefings

- Set expectations
- Clarify responsibilities
- Set the tone within a group
- Task focused
- Should be relaxed
- People centric
- Patient centered
OR Team Briefings

1. Announce Briefing
2. Introduce All Personnel
3. Share Critical Information
4. Ask for Team Input
5. Conduct Time Out
6. Review Contingency Plans
7. Ask for Questions about Case

Every Case Every Patient Every Time

CLINICAL BRIEFINGS™
LEARN MORE

P.S. Click here to schedule your FREE briefing!

Increasing Patient Safety through Effective Communication and Teamwork

Surgical Team Briefing Checklist

Surgical Team Debriefing Checklist

Photo: PilemaCO/123RF

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HTMS HealthTech
Management Services
Key Points about Briefings

• Short – briefings must be succinct
• Informative – briefings should not be idle chat or provide superfluous information
• Structured – briefings are not free verse and open-ended with several people talking at once about what is important to them. Use a briefing checklist.
Checklists and Briefings

Planning for a cardiac catheterization, for instance, begins with a physician's examination of a patient and identification of tests that help him or her make a diagnosis. He or she may then present the case to a broader team of experts at a service specific planning conference (ex: cardiac cath conference). Meanwhile, professional staff in the cath lab prepare the facility according to a standard set up (preference cards) designed to support specific procedures.

Checklists. Checklists consist of a standardized list of events to be executed by a given stage in a process. Pilots typically "pre-flight" their aircraft before taking their place in the cockpit.

Briefing. A pre-procedural briefing can be used effectively to bring the team together one last time to review the planning.
Timeouts
Good trauma care

- Quiet – leader speaks, others answer report, not everyone trying to scream over each other
- Organized – pre-assigned roles and responsibilities of team members

Access  Control
Central Line  Invasions

Patient

Away

Central Line  Invasions

Leader

Heart Sync

Remote
Tools for Effective Teams

• *See It*- Red Flags. One effective method for team identification of potential adverse events is for the team to agree upon a basic set of Red Flag indicators. Two examples might include:
  a) conflicting inputs, and
  b) violation of procedures.
Some areas may establish physiological parameters as Red Flags, such as blood pressures or oxygen saturations exceeding certain limits. Effective teams ensure that all team members are educated on recognition of Red Flags.
Examples of Red Flags

- You pull your meds from Pyxis and take to the patient’s bedside. The patient looks at the medications, and says “these two pills aren’t the color of the pills I take at home”. What do you do?
- During morning bedside rounds, you notice that the patient is grimacing and flopping around in the bed. You ask when she pressed the PCA button. She tells you that she pressed the button about 5 minutes ago. You ask her what her pain level is on a scale of 1-10. She tells you it is 10. What do you do?
- A patient comes to your endoscopy suite, and the surgeon tells you to begin moderate sedation and says he’ll be back when the patient is ready and leaves the room. Your protocol says that the surgeon should be quickly available in case you need him, but he has told you that he has to go back to his office. What do you do?
- You’re the circulator in the OR, and the surgeon keeps telling you, “Let’s get going, let’s role”, however the timeout has not been done. What do you do?
Clinical Red Flags

• Failed cross-check
• Failure to meet targets
• Not addressing discrepancies
• Failure to delegate
• Not following policy
• Confusion
• Fixation
• Not communicating
What do you see?
Good teams learn to communicate concisely and precisely. These teams learn to avoid the "hint and hope" method of talking around an issue (ex: "Are you sure you want to do that?"). While effective teams know how to address routine issues, they learn different techniques for calling attention to more critical needs.
Hint-and-Hope Communication

Hint and Hope - when someone wants another person to do something specific, or change behavior, but is unwilling to address the issue directly. Regularly used in relationships.
Clinical Hint and Hope Communication

• Has been the norm in healthcare.
• “Fraught with risk”. Source: Leonard, Graham, & Bonacum. 2004
• Approachability of physicians
• Introductory communication: “I’m sorry to bother you”.
• Intimidation-use of sticky notes vs. face-to-face or phone conversation
• Inconsistent approach to reporting concern
Use of the 3Ws

- What I see
- What I’m concerned about
- What I want

Examples:

What I see - Mr. Smith has a temp of 100°, white count is elevated at 12,000, his incision is red and warm, but no drainage, and he does not want to get up and ambulate.

What I’m concerned about - I’m concerned that he may be developing a post-op infection.

What I want - I want you to reevaluate Mr. Smith before you leave the floor.
Followership

The concept of *follower* when using CRM connotes an active process and assertiveness, not passivity.
Essential Elements of Followership

- Sense of Responsibility
  - Integral part in decision making
  - Accept ownership for quality care
  - Uses critical thinking to avoid risks
- Pride in team performance
- Assure patient safety

Question everything
Be assertive!
Speak up!!
Don’t accept things at face value
Kelly’s Model of Followership

Independent, Critical Thinking
Alienated
Effective
Pragmatic Survivor
Passive
Conformist
Dependent, Uncritical Thinking
Advocacy

You are willing and prepared to bring forward an alternative course of action even if it is contrary to what is accepted.

Examples:

❖ A nurse caring for a septic patient in an ICU queries a physician regarding why a particular antibiotic was discontinued.

❖ When discussing a frail, elderly patient during handoff report, a nurse asks the charge nurse why the patient has not been placed on high-risk fall precautions.
Culture of Safety

• The safety culture of an institution is defined by the collective habits, processes and actions of their staff.

• An understanding of that culture is an essential basis for improvement.

Link: AHRQ.gov for a Hospital Safety Survey Assessment
Lessons Learned

• Healthcare can create a safer environment by using CRM principles and tools.
• Patient safety involves every member of the healthcare team.
• When safety is compromised, it is the responsibility of each team member to speak up regardless of status.
• Involve those who provide care in the development of checklists and assure consistency in using these tools.
• Always do what’s right, and you will never be wrong.
• Empower staff to make the right decisions at the right time.
Thanks for taking the time today to identify different ways to keep patients safe!!